



# **Anthem Blue Cross and Blue Shield Provider and Facility Manual**

Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

## Table of Contents

<b>Introduction and Guide to Manual .....</b>	<b>8</b>
<i>Purpose and Introduction.....</i>	<i>8</i>
<b>Legal and Administrative Requirements Overview .....</b>	<b>10</b>
<i>Coordination of Benefits .....</i>	<i>10</i>
<i>Dispute Resolution and Arbitration .....</i>	<i>11</i>
<i>Financial Institution/Merchant Fees .....</i>	<i>13</i>
<i>Insurance Requirements.....</i>	<i>13</i>
<i>Member Satisfaction Survey/Feedback – Pain Treatment.....</i>	<i>14</i>
<i>Misrouted Protected Health Information (PHI).....</i>	<i>14</i>
<i>Network Adequacy.....</i>	<i>14</i>
<i>On-call Coverage for Primary Care Physicians .....</i>	<i>19</i>
<i>Open Practice .....</i>	<i>19</i>
<i>Publication and Use of Provider and Facility Information.....</i>	<i>19</i>
<i>Release of Information/Confidentiality.....</i>	<i>19</i>
<i>Risk Adjustments .....</i>	<i>20</i>
<b>Directory of Services/Provider Resource Information .....</b>	<b>23</b>
<i>Provider Contact Information.....</i>	<i>23</i>
<i>Provider Communications/Notifications and Provider Newsletters.....</i>	<i>23</i>
<i>Provider Education and Training.....</i>	<i>24</i>
<i>Provider In-Service.....</i>	<i>24</i>
<i>Online Provider Directories and Demographic Data Integrity.....</i>	<i>24</i>
<i>Primary Care Physician Change Request.....</i>	<i>26</i>
<i>Member Notification Regarding Provider Termination.....</i>	<i>27</i>
<b>Availity Portal .....</b>	<b>27</b>
<b>Eligibility .....</b>	<b>30</b>
<i>Member Health Plan ID Cards.....</i>	<i>30</i>
<i>Verifying Member Coverage .....</i>	<i>30</i>
<b>Claims Submission .....</b>	<b>30</b>
<i>Claim Submission Filing Tips.....</i>	<i>30</i>
<i>Type of Billing Codes .....</i>	<i>35</i>
<i>Claim Inquiry/Adjustment Filing Tips .....</i>	<i>35</i>
<i>National Drug Codes (“NDC”).....</i>	<i>39</i>

<i>Recommended Fields for Paper CMS Form 1500 (02-12) Claims .....</i>	<i>45</i>
<i>Timely Filing .....</i>	<i>54</i>
<i>Medical Records Submission (Solicited and Unsolicited).....</i>	<i>55</i>
<i>Electronic Data Interchange (“EDI”) Overview.....</i>	<i>57</i>
<i>Overpayments .....</i>	<i>58</i>
<i>Medicare Crossover.....</i>	<i>61</i>
<b>Claim Action Request Procedures .....</b>	<b>65</b>
<i>When to Submit a Claim Action Request.....</i>	<i>65</i>
<i>How to Submit a Claim Action Request.....</i>	<i>65</i>
<i>Where to Send Completed Claim Action Request.....</i>	<i>65</i>
<i>Who to Contact with Questions about Claim Action Requests .....</i>	<i>66</i>
<b>Provider Complaint and Dispute Resolution (Appeals) Process.....</b>	<b>66</b>
<b>Member Grievance and Appeal Process.....</b>	<b>69</b>
<i>Member Appeals.....</i>	<i>69</i>
<i>How a Member can Obtain Language Assistance.....</i>	<i>73</i>
<b>Member Quality of Care (“QOC”) / Quality of Service (“QOS”) Investigations .....</b>	<b>73</b>
<i>Overview .....</i>	<i>73</i>
<i>Corrective Action Plans (“CAP”) .....</i>	<i>74</i>
<i>Reporting.....</i>	<i>74</i>
<i>Severity Levels for Quality Assurance.....</i>	<i>74</i>
<i>Trend Threshold for Analysis.....</i>	<i>75</i>
<b>Reimbursement Guidelines and Policies .....</b>	<b>76</b>
<i>Reimbursement Policies are available online.....</i>	<i>76</i>
<i>Blood, Blood Products, Processing, Storage and Administration .....</i>	<i>77</i>
<i>Coding Requirements .....</i>	<i>77</i>
<i>Comprehensive Health Planning .....</i>	<i>77</i>
<i>Courtesy Room .....</i>	<i>78</i>
<i>Daily Supply or One Time Charge Fees/Items .....</i>	<i>78</i>
<i>Different Settings Charges .....</i>	<i>78</i>
<i>Eligibility and Payment.....</i>	<i>78</i>
<i>Emergency Room Supply and Services Charges .....</i>	<i>78</i>
<i>Facility Personnel Charges .....</i>	<i>78</i>
<i>General Industry Standard Language .....</i>	<i>79</i>
<i>Implants .....</i>	<i>79</i>

<i>Instrument Trays</i> .....	79
<i>IV Sedation and local anesthesia</i> .....	79
<i>Lab Charges</i> .....	80
<i>Labor Care Charges</i> .....	80
<i>Medical Care Provided to or by Family Members</i> .....	80
<i>Neuromonitoring (technical component)</i> .....	80
<i>Non-Participating Provider Claims Payment</i> .....	80
<i>Nursing Procedures</i> .....	81
<i>Operating Room Time and Procedure Charges</i> .....	81
<i>Other Agreements Excepted</i> .....	81
<i>Personal Care Items</i> .....	82
<i>Pharmacy Charges</i> .....	82
<i>Portable Charges</i> .....	82
<i>Pre-Operative Care or Holding Room Charges</i> .....	82
<i>Preparation (Set-Up) Charges</i> .....	82
<i>Preventable Adverse Events (“PAEs”) (Facility Reimbursement Policy)</i> .....	83
<i>Provider and Facility Records</i> .....	85
<i>Psychiatric Outpatient/Residential Services</i> .....	85
<i>Recovery Room Charges</i> .....	86
<i>Recovery Room Services related to IV sedation and/or local anesthesia</i> .....	86
<i>Routine Supplies</i> .....	86
<i>Semi Private Room Rate</i> .....	86
<i>Special Procedure Room Charge</i> .....	87
<i>Stand-by Charges</i> .....	87
<i>Stat Charges</i> .....	87
<i>Submission of Claim/Encounter Data</i> .....	87
<i>Supplies and Equipment</i> .....	87
<i>Tech Support Charges</i> .....	88
<i>Telemetry</i> .....	88
<i>Test or Procedures Prior to Admission(s) or Outpatient Services</i> .....	88
<i>Time Calculation</i> .....	89
<i>Unapproved Rate Changes</i> .....	90
<i>Undocumented or Unsupported Charges</i> .....	90
<i>Video Equipment used in Operating Room</i> .....	90
<i>Additional Reimbursement Guidelines for Disallowed Charges</i> .....	91
<i>Copayments/Cost Shares</i> .....	97

Member's Liability .....	98
Third-Party Liability .....	99
<b>Medical Policies and Clinical Utilization Management ("UM") Guidelines .....</b>	<b>100</b>
<i>Medical Policy and Clinical Utilization Management ("UM") Guidelines Distinction.....</i>	<i>100</i>
<i>Medical Policies and Clinical UM Guidelines are posted online at anthem.com.....</i>	<i>100</i>
<b>Utilization Management .....</b>	<b>101</b>
<i>Utilization Management Program .....</i>	<i>101</i>
<i>UM Definitions .....</i>	<i>101</i>
<i>Program Overview .....</i>	<i>102</i>
<i>Pre-Service Review &amp; Continued Stay Review .....</i>	<i>103</i>
<i>Medical Policies and Clinical UM Guidelines.....</i>	<i>104</i>
<i>On-Site Review .....</i>	<i>104</i>
<i>Discharge Planning .....</i>	<i>105</i>
<i>Observation Bed Policy.....</i>	<i>105</i>
<i>Retrospective Utilization Management .....</i>	<i>105</i>
<i>Failure to Comply With Utilization Management Program .....</i>	<i>105</i>
<i>Utilization Statistics Information.....</i>	<i>106</i>
<i>Electronic Data Exchange.....</i>	<i>106</i>
<i>Interactive Care Reviewer (ICR).....</i>	<i>106</i>
<i>Peer to Peer Review Process .....</i>	<i>107</i>
<i>Quality of Care Incident.....</i>	<i>108</i>
<i>Audits/Records Requests.....</i>	<i>108</i>
<i>Case Management .....</i>	<i>108</i>
<i>For information on which services require prior authorization under the terms of the plan .....</i>	<i>108</i>
<i>Minimum timeframe and information needed for filing a pre-service / prior-authorization request.....</i>	<i>109</i>
<b>AIM Specialty Health® (AIM).....</b>	<b>110</b>
<i>Submit Pre-certification requests to AIM.....</i>	<i>111</i>
<i>OptiNet® Registration .....</i>	<i>111</i>
<b>Credentialing .....</b>	<b>112</b>
<i>Anthem's Discretion .....</i>	<i>112</i>
<i>Credentialing Scope.....</i>	<i>112</i>
<i>Credentials Committee.....</i>	<i>114</i>
<i>Nondiscrimination Policy.....</i>	<i>115</i>
<i>Initial Credentialing .....</i>	<i>116</i>

<i>Recredentialing .....</i>	<i>117</i>
<i>Health Delivery Organizations .....</i>	<i>117</i>
<i>Ongoing Sanction Monitoring .....</i>	<i>118</i>
<i>Appeals Process.....</i>	<i>118</i>
<i>Reporting Requirements .....</i>	<i>119</i>
<i>Anthem Credentialing Program Standards .....</i>	<i>119</i>
<b>Standards of Participation .....</b>	<b>135</b>
<i>Become a contracted Provider or Facility.....</i>	<i>135</i>
<b>Quality Improvement Program .....</b>	<b>136</b>
<b>Overview of HEDIS® .....</b>	<b>143</b>
<b>Overview of CAHPS® .....</b>	<b>144</b>
<b>Clinical Practice Guidelines .....</b>	<b>144</b>
<b>Preventive Health Guidelines.....</b>	<b>145</b>
<b>Medical Record Standards .....</b>	<b>145</b>
<b>Multicultural Health .....</b>	<b>146</b>
<i>Multicultural Health Overview .....</i>	<i>146</i>
<i>Anthem Innovation .....</i>	<i>147</i>
<i>Medication Adherence .....</i>	<i>150</i>
<b>Centers of Medical Excellence .....</b>	<b>150</b>
<b>Product/Network Summary.....</b>	<b>155</b>
<i>Networks Overview .....</i>	<i>155</i>
<i>Networks at a Glance.....</i>	<i>155</i>
<i>BlueCard Program .....</i>	<i>155</i>
<i>HMO Colorado Point-of-Service Rider.....</i>	<i>155</i>
<i>HMO Colorado Away from Home Care® Program .....</i>	<i>156</i>
<b>Medicare Advantage.....</b>	<b>158</b>
<i>Medicare Advantage Provider Website .....</i>	<i>158</i>
<b>Federal Employees Health Benefits Program .....</b>	<b>158</b>
<i>FEHBP Requirements.....</i>	<i>158</i>
<i>Submission of Claims under the Federal Employees Health Benefits Program .....</i>	<i>158</i>
<i>Erroneous or duplicate Claim payments under the FEHBP.....</i>	<i>159</i>

<i>Coordination of Benefits for FEHBP</i> .....	159
<i>FEHBP Waiver requirements</i> .....	159
<i>FEHBP Member Reconsiderations and Appeals</i> .....	159
<i>FEHBP Formal Provider and Facility Appeals</i> .....	160
<i>FEHBP Inpatient Skilled Nursing Facility Care</i> .....	161
<b>BlueCard Program Overview</b> .....	<b>162</b>
<b>Health Insurance Marketplace (exchanges)</b> .....	<b>163</b>
<i>Health Insurance Marketplace</i> .....	163
<i>Affordable Care Act (ACA) – Quick Reference Guide</i> .....	163
<b>Audit</b> .....	<b>163</b>
<i>Anthem Audit Policy</i> .....	163
<i>Audit Appeal Policy</i> .....	170
<b>Fraud, Waste and Abuse Detection</b> .....	<b>171</b>
<i>Investigation Process</i> .....	172
<i>Prepayment Review</i> .....	172
<i>Acting on Investigative Findings</i> .....	173
<i>Recoupment/Offset/Adjustment for Overpayments</i> .....	173
<b>Pharmacy Home Program</b> .....	<b>174</b>
<b>Laboratory Services</b> .....	<b>176</b>
<i>Laboratory Procedures</i> .....	176
<i>Other Considerations</i> .....	179
<i>Specialized Anatomic Pathology</i> .....	180
<i>LabCorp Patient Service Centers</i> .....	180
<b>Pharmacy Services</b> .....	<b>180</b>
<i>Prescription Drug Benefit Design</i> .....	180
<i>Specialty Medications</i> .....	182
<i>Clinically Equivalent Medications Program</i> .....	182
<i>GenericSelect Program</i> .....	183
<i>Half-Tab Program</i> .....	183
<i>Home Delivery Pharmacy Program</i> .....	183
<i>Specialty Pharmacy Services</i> .....	183
<i>Pharmacy Benefit Management and Drug List/Formulary</i> .....	184

<b>Behavioral Health and Chemical Dependency Rehabilitation Services .....</b>	<b>185</b>
<i>Authorizations.....</i>	<i>186</i>
<i>Detoxification.....</i>	<i>186</i>
<i>Utilization Management.....</i>	<i>187</i>
<i>Anthem Behavioral Health Contact Information.....</i>	<i>187</i>
<i>Depression Pocket Guide.....</i>	<i>188</i>
<b>Chiropractic, Acupuncture, Massage and Nutritional Therapy Services .....</b>	<b>189</b>
<i>PPO and Indemnity.....</i>	<i>189</i>
<i>HMO (Chiropractic, Acupuncture and Massage Therapy).....</i>	<i>189</i>
<i>Workers’ Compensation.....</i>	<i>189</i>
<i>Provider Guidelines .....</i>	<i>190</i>
<i>Anthem Workers’ Compensation Payers Accessing the Participating and PPO Occupational Medicine Network</i>	<i>191</i>
<i>Rules for Calculating Permanent Disability .....</i>	<i>192</i>
<i>Grievances.....</i>	<i>192</i>
<i>Additional Information.....</i>	<i>192</i>
<b>Glossary .....</b>	<b>192</b>
<b>Exhibits .....</b>	<b>199</b>
<b>Appendices .....</b>	<b>200</b>
<b>Links .....</b>	<b>200</b>

---

## Introduction and Guide to Manual

### [Purpose and Introduction](#)

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

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.

Anthem is redesigning the provider public website to make it easier and more useful for Providers and Facilities. Anthem is working hard to move resources into the new redesigned website for an enhanced experience. In the meantime, Providers and Facilities can still access most of our resources on our legacy site. It is possible that links or navigation instructions within this Manual may not work during this transition time. Anthem will work to minimize any disruption during this time.

We know how complicated the health insurance and managed care industry has become, and we understand how that complexity can affect your office or facility. The Manual contains information about claims submission, reimbursement processes and methodology, authorizations, who to contact at Anthem and other key information to make doing business with together as easy as possible.

Anthem retains the right to add to, delete from, and otherwise modify this Manual. Providers and Facilities must acknowledge this Manual and any other written materials provided by Anthem as proprietary and confidential. If there is a conflict with the Manual and your Agreement, your Agreement supersedes. We encourage you to contact your Anthem contracting representative whenever you need clarification or if you have any suggestions for improvement to the Manual. If you don’t know who your assigned contracting representative is, please reference the [Escalation Contact List](#), or go to **anthem.com**. Select **Providers**. Under the *Communications* heading, select **Contact Us**. Choose **Colorado**, then select [Escalation Contact List](#).

Any 5-digit numerical physician Current Procedural Terminology (“CPT”) codes, service descriptions, 2-digit modifiers, instructions and/or related guidelines are copyright © 2019 by the American Medical Association (“AMA”). All rights reserved.

This Manual includes CPT codes selected by Anthem. No fee schedules, basic unit values, relative value guides, maximum allowances, conversion factors or scales are included in CPT. The AMA assumes no responsibility for any information contained or not contained in this Manual. The AMA doesn’t directly or indirectly practice medicine or dispense medical services.

*Please note: Material in this Manual is subject to change. The most up-to-date version is available online. Go to **anthem.com**, and select **Providers**. Under the *Provider Resources* heading, select **Policies, Guidelines, and Manuals**. Select **Colorado** if you haven’t done so already. Under the *Provider Manual* heading, select, [Download the Manual](#).*

## Legal and Administrative Requirements Overview

### 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](https://www.anthem.com)**, and select **Providers**. Under the *Claims* heading, select **[Electronic Data Interchange](#)**. Select **Colorado** if you haven’t done so already.

### **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 attorneys' fees) the dollar thresholds set forth in the Dispute Resolution and Arbitration article of the Agreement then the panel shall be selected in the following manner. The arbitration panel shall consist of one (1) arbitrator selected by Provider/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 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.

#### [Member Satisfaction Survey/Feedback – Pain Treatment](#)

Anthem shall not take an adverse action against Provider or Facility, or provide financial incentives, or subject the Provider or Facility to financial disincentives based solely on a Member satisfaction survey or other method of obtaining Member feedback relating to the Member's satisfaction with pain treatment.

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

Providers and Facilities are required to review all Member 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. 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.

#### [Network Adequacy](#)

Anthem has established and monitors network adequacy standards to help ensure that our members have adequate, appropriate and timely access to PCPs (family and general practitioners, internists and pediatricians who have agreed to act as PCPs),

high-volume specialists, hospitals and other health care providers. These adequacy standards include the number of providers, the geographic distribution of providers, and timely access for routine, emergency and urgent care conditions.

## Colorado Access and Availability Standards

### ***Accessibility – Plan’s members can obtain available services:***

- The distance you must travel to see a provider receive hospital services.
- The percentage of PCPs accepting new members, i.e., those who have “open” practices.
- The number of PCPs compared to the number of members
- The waiting time between your call for an appointment and the appointment time and date.
- The on-call or after-hours availability of providers.
- The volume of technological and specialty services available to serve your needs when you require covered technologically advanced or specialty care.
- Linguistic and cultural capability of the provider

Access is defined as the timeliness in which you are able to obtain available services

Network Access to Care Standards		
Service Type	Time Frame	Goal/Threshold
Emergency Care – Medical, Behavioral, Substance Abuse	24 hours a day, 7 days a week.	Met 100% of the time
Urgent medical care - Medical, Behavioral, Substance Abuse	Within 24 hours	Met 100% of the time
Primary Care – Routine, non-urgent symptoms	Within 7 calendar days	Met ≥ 90% of the time
Primary Care Access to after-hours care	Office number answered 24/7 days a week by answering service or instruction on how to reach a physician	Met ≥ 90% of the time
Prenatal Care	Within 7 calendar days	Met ≥ 90% of the time
PCP and Specialist – Open practice	See goal	Met ≥ 90% of the time
Preventive visit/well visits	Within 30 calendar days	Met ≥ 90% of the time
Specialty Care – non-urgent	Within 60 calendar days	Met ≥ 90% of the time
Behavioral, Mental, and Substance Abuse after-hour care	Office number answered 24/7 days a week by answering	Met ≥ 90% of the time

Network Access to Care Standards		
Service Type	Time Frame	Goal/Threshold
	service or instruction on how to reach a physician	
Behavioral, Mental and Substance Abuse Emergency Care – non-LT	Within 6 hours	Met 85% of the time
Behavioral Health, Mental Health, and Substance Abuse Care – Initial Routine, non-urgent, non-emergency	Within 7 calendar days	Met ≥ 90% of the time
Behavioral Health, Mental Health, and Substance Abuse Care – Follow-up, non- urgent, non-emergency	Within 30 calendar days	Met ≥ 85% of the time

Availability is defined as the extent to which providers of the appropriate type and number are distributed geographically in our networks to meet the needs of our members.

Network Availability Mileage Standards					
Specialty	Geographic Type				
	Large			Rural	CEAC
	Metro	Metro	Micro		
	Maximum Distance (miles)	Maximum Distance (miles)	Maximum Distance (miles)	Maximum Distance (miles)	Maximum Distance (miles)
Primary Care	5	10	20	30	60
Gynecology, OB/GYN	5	10	20	30	60
Pediatrics - Routine/Primary Care	5	10	20	30	60
Allergy and Immunology	15	30	60	75	110
Cardiothoracic Surgery	15	40	75	90	130
Cardiovascular Disease	10	20	35	60	85
Chiropracty	15	30	60	75	110
Dermatology	10	30	45	60	100
Endocrinology	15	40	75	90	130
ENT/Otolaryngology	15	30	60	75	110
Gastroenterology	10	30	45	60	100
General Surgery	10	20	35	60	85
Gynecology only	15	30	60	75	110
Infectious Diseases	15	40	75	90	130
Licensed Clinical Social Worker	10	30	45	60	100



Nephrology	15	30	60	75	110
Neurology	10	30	45	60	100
Neurological Surgery	15	40	75	90	130
Oncology - Medical, Surgical	10	30	45	60	100
Oncology - Radiation/Radiation Oncology	15	40	75	90	130
Ophthalmology	10	20	35	60	85
Orthopedic Surgery	10	20	35	60	85
Physiatry, Rehabilitative Medicine	15	30	60	75	110
Plastic Surgery	15	40	75	90	130
Podiatry	10	30	45	60	100
Psychiatry	10	30	45	60	100
Psychology	10	30	45	60	100
Pulmonology	10	30	45	60	100
Rheumatology	15	40	75	90	130
Urology	10	30	45	60	100
Vascular Surgery	15	40	75	90	130
OTHER MEDICAL PROVIDER	15	40	75	90	130
Dental	15	30	60	75	110
Pharmacy	5	10	20	30	60
Acute Inpatient Hospitals	10	30	60	60	100
Cardiac Surgery Program	15	40	120	120	140
Cardiac Catheterization Services	15	40	120	120	140
Critical Care Services – Intensive Care Units (ICU)	10	30	120	120	140
Outpatient Dialysis	10	30	50	50	90
Surgical Services (Outpatient or ASC)	10	30	60	60	100
Skilled Nursing Facilities	10	30	60	60	85
Diagnostic Radiology	10	30	60	60	100
Mammography	10	30	60	60	100
Physical Therapy	10	30	60	60	100

Occupational Therapy	10	30	60	60	100
Speech Therapy	10	30	60	60	100
Inpatient Psychiatric Facility	15	45	75	75	140
Orthotics and Prosthetics	15	30	120	120	140
Outpatient Infusion/Chemotherapy	10	30	60	60	100
OTHER FACILITIES	15	40	120	120	140

Member to Provider Ratios			
Provider/Facility Type	Large Metro	Metro	Micro
Primary Care	1:1000	1:1000	1:1000
Pediatrics	1:1000	1:1000	1:1000
OB/GYN	1:1000	1:1000	1:1000
Mental health, behavioral health and substance abuse disorder Care Providers	1:1000	1:1000	1:1000

The follow table defines geographic type:

Classification	Counties
Large Metro	Denver
Metro	Adams, Arapahoe, Boulder, Broomfield, Douglas, El Paso, Jefferson, Larimer, and Weld
Micro	Eagle, Garfield, La Plata, Mesa, and Pueblo
Rural	Alamosa, Chaffee, Clear Creek, Delta, Elbert, Fremont, Gilpin, Lake, Logan, Montezuma, Montrose, Morgan, Otero, Pitkin, Rio Grande, Summit, and Teller
CEAC – (Counties with Extreme Access Considerations)	Archuleta, Baca, Bent, Cheyenne, Conejos, Costilla, Crowley, Custer, Dolores, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Kiowa, Kit Carson, Las Animas, Lincoln, Mineral, Moffat, Ouray, Park, Phillips, Prowers, Rio Blanco, Routt, Saguache, San Juan, San Miguel, Sedgwick, Washington, and Yuma

## After Hours

After hours care is provided by physicians who may have a variety of ways of addressing members' needs. Members should call his/her PCP for instructions on how to receive medical care after the PCP's normal business hours, on weekends and holidays, or to receive non-Emergency Care and non-Urgent Care within the service

area for a condition that is not life threatening but that requires prompt medical attention. In case of an Emergency, the Member should call 911 or go directly to the nearest Emergency room. If he/she is outside the service area, non-emergency Covered Service may be covered under the BlueCard Program.

### [On-call Coverage for Primary Care Physicians](#)

PCPs are required to provide twenty-four (24) hour coverage, seven (7) days a week, for Anthem members. After-hours coverage may consist of the following:

- A covering physician who is a PCP in the member's designated PCP's clinic or medical management group, in which case a referral isn't necessary
- The covering physician is a Provider with Anthem, and the covering physician's name is in the Anthem system as an on-call provider for the PCP. When an Anthem member sees an on-call provider, claims are processed at the on-call provider's contracted rate with Anthem.

Please update on-call information, through the [Provider Maintenance Form](#).

### [Open Practice](#)

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

### [Publication and Use of Provider and Facility Information](#)

Anthem or its designees may use, publish, disclose, and display information related to demographics, credentialing, affiliations, performance data, and transparency initiatives, relating to Provider or Facility for commercially reasonable general business purposes.

### [Release of Information/Confidentiality](#)

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

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

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

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

### [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 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 practitioner 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 in the 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 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 medicate, 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 Resource Information

### [Provider Contact Information](#)

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

#### 1. **Prefix Reference List** –

This is a one page list that provides customer service phone numbers, address information for claims, adjustments, appeals, and correspondence, as well as Authorization phone number information.

- This list is split out by member type, as identified by the member's three (3) character prefix in front of their ID number.
- Always utilize the information provided on the member's ID card, but if that's not available, this will help ensure you can contact the appropriate customer service, or authorization unit the first time to avoid unnecessary transfers.

#### 2. **Escalation Contact List** –

This document outlines our escalation process and includes phone numbers and email addresses for our team leads and managers in many of our provider servicing areas. It includes contact information for the following areas:

- Local Provider Customer Service
- Federal Employee Program Provider Customer Service
- BlueCard Provider Customer Service
- Pre-certification/Authorizations
- Electronic Data Interchange ("EDI") Solutions Team
- Colorado Medical Directors Back line
- Provider Engagement and Contracting:
  - Provider Relations
  - Provider Contracting
  - Provider Education/Communication

Our contact information is also posted online. Go to **anthem.com**. Select **Providers**. Under *Communications* heading, select **Contact Us**. Select **Your State**, then select [Escalation Contact List](#) or [Prefix Reference List](#).

### [Provider Communications/Notifications and Provider Newsletters](#)

Our provider communications/notifications are primarily sent via email. Notices of Material Change to Contracts will be sent via email and mail.

Provider Newsletters are published and distributed monthly via email only on the first of each month.

All of our Provider Communications/Notification and Provider Newsletters are posted online at [anthem.com](https://anthem.com).

- Go to <https://providernews.anthem.com/colorado>
- Register to receive our communications via email:  
<https://messageinsite.com/networkupdate>
- Emails will come from Anthem Provider Communications. Please add [ProviderCommunications@email.anthem.com](mailto:ProviderCommunications@email.anthem.com) to your safe sender list.

### [Provider Education and Training](#)

Please check out our Provider Education and Training page for any upcoming opportunities for Provider Education, including Provider Seminars, Provider Webinars, or Working with Anthem webinars.

Our contact information is also posted online. Go to **anthem.com**. Select **Providers**. Under *Communications* heading, select [Education and Training](#). Select **Colorado** if you haven't done so already.

### [Provider In-Service](#)

**Provider In-Services, one-on-one meetings** – Providers and Facilities can request an in-service or one-on-one meeting. If you would like to request a visit, or training on a specific topic, please feel free to contact our Provider Relations Team at [COProviderRelations@anthem.com](mailto:COProviderRelations@anthem.com).

### [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 our Provider Relations team at [COProviderRelations@anthem.com](mailto:COProviderRelations@anthem.com).

Accessing the Online Provider Directory:

Go to **anthem.com**, and select **Providers**. Under the *Provider Resources* heading, select [Find Care](#). Select **Colorado** if you haven't done so already.



To search our online Provider Directory either enter the member prefix 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 a 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 change/update. Any requests received within less than 30 days' notice may be assigned a future effective date. Contractual terms may supersede effective date request.

#### **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

Changes/updates must be submitted using the online [Provider Maintenance Form](#).

Note: for Chiropractic, Acupuncture, Massage Therapist, Nutritionists/dieticians, please contact [American Specialty Health](#): 800-972-4226.

\* 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**, and **Providers Overview**. Select **Find Resources for Your State**, and pick **Colorado**. From the [Join Our Networks](#) tab, select the appropriate link depending on your specialty type.

### [Primary Care Physician Change Request](#)

HMO Colorado Members must select a primary care physician (“PCP”) of their choice from the HMO Colorado network. Customer service processes PCP change requests.

### **Procedure**

- A Member can request to change PCPs by calling HMO Colorado’s customer service department.
- If the Member indicates a potential quality issue or grievance and complaint at the time of the change request, customer service will ask the Member to submit additional information in writing about the potential issue. If we receive written notice of a potential quality issue or grievance and complaint, we’ll send it to the grievance and complaint department for research. An associate from that department will communicate HMO Colorado’s resolution/action related to the potential issue to the Member and to the provider. The grievance and complaint department maintains a copy of this correspondence in its confidential files.
- This process may take at least thirty (30) calendar days for research and processing of a potential quality issue or grievance and complaint that requires investigation.
- Customer service will process the Member’s PCP change request and, if approved, the effective date of the change.

## [Member Notification Regarding Provider Termination](#)

When a Provider or Facility's contract is terminated, Anthem will notify members as required by **C.R.S. 10-16-705 (7) (CO) / state law (NV)** and related regulations, as amended from time to time.

---

### **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 Payment Disputes (Reconsiderations and Appeals)** – Submit and check the status of Claim Payment Reconsiderations and Appeals where applicable. *(For Medicare and Medicaid only.)*
- **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 authorization, referral and inquiry tool for many Anthem members.
- **Medical Attachments** – Submit your medical records electronically when requested to support a pended or denied claim. Includes the ability to submit an itemized bill electronically.
- **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®.
- **Member ID Card Viewer** – View the front and back of a member's ID card when available.

- **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](http://www.availity.com) for a full list of payers.)
- **Compliance** – Availity is compliant with all Health Insurance Portability and Accountability Act (HIPAA) regulations.

## How to get started

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

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

## Availity Training

Once you log into Availity, you'll 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.

---

## Eligibility

### [Member Health Plan ID Cards](#)

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

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

Samples of our Member Health Plan ID Cards are available within our Networks Overview document.

Go to **[anthem.com](http://anthem.com)**, and select **Providers**. Under the *Provider Resources* heading, select **Forms and Guides**. Search for [Networks Overview](#). Select **Colorado** if you haven't done so already.

### [Verifying Member Coverage](#)

Member health plan ID cards include information about verifying member eligibility. Possession of a health plan ID card does not guarantee that the person is an eligible member. Please verify eligibility and benefits either online through the Availity web portal, or through customer service at the number on the back of the member's ID card.

---

## Claims Submission

### [Claim Submission Filing Tips](#)

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

## Electronic Claims Submissions

Please submit 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 Claims on paper, failure to submit them on the most current CMS-1500 (Form 1500 (02-12)) or CMS-1450 (UB04) will cause Claims to be rejected and returned to the Provider or Facility. More information and the most current forms can be found at [www.cms.gov](http://www.cms.gov).

- Submit all paper Claims using the current standard RED CMS Form 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 helps us process 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 your 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](http://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 don't include these lines on the Claim. Negative charges often result in an out-of-balance Claim that must be returned to the provider for additional clarification.

## **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 [Claim Action Request Form](#) or send a secure message through Availity.

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 [Claim Action Request Form](#) for each Claim. Do not submit lists of multiple Claims or multiple members. 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 digit 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 **on 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 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.
  - Medical Records requested (solicited) by Anthem needed for claim processing can be submitted electronically using the Medical Attachments feature on the Availity Portal. The *solicited* Medical Attachments feature supports.tiff, .jpg and .pdf attachment file types.

To access *solicited* Medical Attachments, provider organization Availity administrators should complete the following steps:

From **My Account Dashboard**, select **Enrollments Center>Medical Attachments Setup**, follow the prompts and complete the following sections:

1. Select Application>choose **Medical Attachments Registration**.
2. Provider Management>Select **Organization** from the drop-down. Add NPIs and/or Tax IDs. Multiples can be added separated by spaces or semi-colons.
3. Assign user access by checking the box in front of the user's name. Users may be removed by unchecking their name.

To use Medical Attachments, Availity users should complete the following steps:

1. Log in to [www.availity.com](http://www.availity.com).
  2. Select **Claims and Payments > Medical Attachments > Send Attachment** tab.
  3. Complete all required fields on the form.
  4. Attach supporting documentation.
  5. Select **Submit**.
- **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	<b>To indicate the Claim is a replacement Claim:</b> <ul style="list-style-type: none"> <li>In element CLM05-3 “Claim Frequency Type Code”</li> <li>Use Claim Frequency Type 7</li> </ul>	<b>To indicate the Claim is a replacement Claim:</b> <ul style="list-style-type: none"> <li>In element CLM05-3 “Claim Frequency Type Code”</li> <li>Use Claim Frequency Type 7</li> </ul>
	<b>To confirm the Claim which is being replaced:</b> <ul style="list-style-type: none"> <li>In Segment “REF – Payer Claim Control Number”</li> <li>Use F8 in REF) and list the original payer Claim number is REF02</li> </ul>	<b>To confirm the Claim which is being replaced:</b> <ul style="list-style-type: none"> <li>In Segment “REF – Payer Claim Control Number”</li> <li>Use F8 in REF) and list the original payer Claim number is REF02</li> </ul>
	<b>To indicate the Claim was billed in error (Void/Cancel):</b> <ul style="list-style-type: none"> <li>In element CLM05-3 “Claim Frequency Type Code”</li> <li>Use Claim Frequency Type 8</li> </ul>	<b>To indicate the Claim was billed in error (Void/Cancel):</b> <ul style="list-style-type: none"> <li>In element CLM05-3 “Claim Frequency Type Code”</li> <li>Use Claim Frequency Type 8</li> </ul>
	<b>To confirm the Claim which is being void/cancelled:</b> <ul style="list-style-type: none"> <li>In Segment “REF – Payer Claim Control Number”</li> <li>Use F8 in REF) and list the original payer Claim number is REF02</li> </ul>	<b>To confirm the Claim which is being void/cancelled:</b> <ul style="list-style-type: none"> <li>In Segment “REF – Payer Claim Control Number”</li> <li>Use F8 in REF) and list the original payer Claim number is REF02</li> </ul>
Paper	<b>To indicate the Claim is a replacement Claim:</b> <ul style="list-style-type: none"> <li>In Item Number 22: “Resubmission and/or Original Reference Number”</li> <li>Use Claim Frequency Type 7 under “Resubmission Code”</li> </ul>	<b>To indicate the Claim is a replacement Claim:</b> <ul style="list-style-type: none"> <li>In Form Locator 04: “Type of Bill”</li> <li>Use Claim Frequency Type 7</li> </ul>
	<b>To confirm the Claim which is being replaced:</b> <ul style="list-style-type: none"> <li>In the right-hand side of Item Number 22 under “Original Ref. No.” list the original payer Claim number for the resubmitted Claim.</li> </ul>	<b>To confirm the Claim which is being replaced:</b> <ul style="list-style-type: none"> <li>In Form Locator 64: “Document Control Number (DCN)” list the original payer Claim number for the resubmitted Claim.</li> </ul>
	<b>To indicate the Claim is a void/cancel of a prior Claim:</b>	<b>To indicate the Claim is a void/cancel of a prior Claim:</b>

Type	Professional Claim	Institutional Claim
	<ul style="list-style-type: none"> <li>In Item Number 22: "Resubmission and/or Original Reference Number"</li> <li>Use Claim Frequency Type 8 under "Resubmission Code"</li> </ul>	<ul style="list-style-type: none"> <li>In Form Locator 04: "Type of Bill"</li> <li>Use Claim Frequency Type 8</li> </ul>
	<b>To confirm the Claim which is being void/cancelled:</b> <ul style="list-style-type: none"> <li>In the right-hand side of Item Number 22 under "Original Ref. No." list the original payer Claim number for the void/cancelled Claim.</li> </ul>	<b>To confirm the Claim which is being void/cancelled:</b> <ul style="list-style-type: none"> <li>In Form Locator 64: "Document Control Number (DCN)" list the original payer Claim number for the void/cancelled Claim.</li> </ul>

For additional information, please contact Provider Customer Service.

### 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 on a claim regarding drugs administered in a physician office or outpatient facility setting for all drug categories **will deny** if they do not include the following:

- Applicable HCPCS code or CPT code
- Number of HCPCS code or CPT code units
- The valid 11-digit NDC, **including the N4 qualifier**
- Unit of measure qualifier (F2, GR, ML, UN, MG)
- NDC Units dispensed (must be greater than 0)

### **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
- MG - 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.



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	<b>0</b> 12341234 <b>0</b> 1



NDC 12345-123-12 (5-3-2 format)	Needs a leading zero placed at the beginning of the second segment	12345 <b>0</b> 12312
NDC 12345-1234-1 (5-4-1 format)	Needs a leading zero placed at the beginning of the third segment	123451234 <b>0</b> 1

### 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 00054352763 is entered as N400054352763	Beginning at left edge, enter NDC in the <b>shaded area</b> of box 24A
Enter one of five (5) units of measure qualifiers; <ul style="list-style-type: none"> <li>F2 – International Unit</li> <li>GR – Gram</li> <li>ML – Milliliter</li> <li>UN – Units</li> <li>MG – Milligrams</li> </ul> and quantity, <b>including a decimal point for correct reporting</b>	GR0.045 ML1.0 UN1.000	In the <b>shaded area</b> immediately following the 11-digit NDC, enter 3 spaces, followed by one of five (5) units 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 ampul used	<b>Non-shaded area</b> of box 24D

24. A. DATE(S) OF SERVICE				B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINT	F. \$ CHARGES	G. DAYS OR UNITS	H. (PST) Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	PHYSICIAN OR SUPPLIER INFORMATION
MM	DD	YY	MM	DD	YY	CPT/HCPCS	MODIFIER						
1												NPI	
2												NPI	
3												NPI	
4												NPI	
5												NPI	

Enter NDC in shaded area of box 24A

**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 N4 qualifier	NDC 00054352763 is entered as N400054352763	Beginning at left edge, enter NDC In locator (box) 43 currently labeled as "Description"
Enter one of five (5) units of measure qualifiers; <ul style="list-style-type: none"> <li>• F2 – International Unit</li> <li>• GR - Gram</li> <li>• ML - Milliliter</li> <li>• UN – Units</li> <li>• MG - Milligrams</li> </ul> and quantity, <b>including a decimal point for correct reporting</b>	GR0.045 ML1.0 UN1.000	Immediately following the 11 digit NDC, enter 3 spaces followed by one of five (5) units of measure qualifiers, followed immediately by the quantity.
Enter a valid HCPCS or CPT Code	J0610 "injection Calcium, per 10ML" is billed as 1 unit for each 10ML ampul used	Form locator (box 44)

**Sample Images of the UB04 Claim Form**

42 REV. CO.	43 DESCRIPTION	44 HCPCS / RATE / HIPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NONCOVERED CHARGES	49
	Enter NDC in locator (box) 43					0:00	
						0:00	
						0:00	

42 REV. CO.	43 DESCRIPTION	44 HCPCS / RATE / HIPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NONCOVERED CHARGES	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	<b>LIN02</b>	Product or Service ID Qualifier	Enter product or NDC qualifier N4	LIN**N4*01234567891~
2410	<b>LIN03</b>	Product or Service ID	Enter the NDC	LIN**N4* <b>01234567891</b> ~
2410	<b>CTP04</b>	Quantity	Enter quantity billed	CTP**** <b>2</b> *UN~
2410	<b>CTP05-1</b>	Unit of Basis for Measurement Code	Enter the NDC unit of measurement code: F2: International unit GR: Gram ML: Milliliter UN: Unit MG: Milligram	CTP**** <b>2</b> *UN~
2410	<b>REF01</b>	Reference ID Qualifier (used to report Prescription # <b>or</b> Link Sequence Number when reporting components for a Compound Drug)	VY: Link Sequence Number XZ : Prescription Number	REF01* <b>XZ</b> *123456~
2410	<b>REF02</b>	Reference Identification	Prescription Number <b>or</b> Link Sequence Number	REF01*XZ* <b>123456</b> ~

[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](http://www.anthem.com/edi). **Select your state.** 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 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 than the insured's address. If it's 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](http://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), MG (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 numerics 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

<input type="checkbox"/> PICA										<input type="checkbox"/> PICA																																																	
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)										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:										11. INSURED'S POLICY GROUP OR FECA NUMBER																																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																																							
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) ( )										b. OTHER CLAIM ID (Designated by NUCC)																																							
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>										c. INSURANCE PLAN NAME OR PROGRAM NAME																																							
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.																																							
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.																				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 _____																				SIGNED _____																																							
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.																				15. OTHER DATE QUAL. MM DD YY																				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. 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? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES																				22. RESUBMISSION CODE ORIGINAL REF. NO.																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 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. EPSIT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #																																																											
1																				NPI																																							
2																				NPI																																							
3																				NPI																																							
4																				NPI																																							
5																				NPI																																							
6																				NPI																																							
25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>										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.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # ( )																																							
SIGNED _____										a. NPI b. _____										a. NPI b. _____																																							

NUCC Instruction Manual available at: [www.nucc.org](http://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), MG (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. # b. MED. REG. # 5 FED. TAX NO.										4 TYPE OF BILL																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																													
8 PATIENT NAME										9 PATIENT ADDRESS										6 STATEMENT COVERS PERIOD FROM THROUGH										7																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																													
10 BIRTHDATE										11 SEX										12 DATE										13 ADMISSION HR										14 TYPE										15 SRC										16 DHR										17 STAT										18										19										20										21										22										23										24										25										26										27										28										29 ACCT STATE										30																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																			
31 OCCURRENCE DATE										32 CODE										33 OCCURRENCE DATE										34 CODE										35 OCCURRENCE DATE										36 CODE										37 OCCURRENCE DATE										38										39 VALUE CODES AMOUNT										40 CODE										41 VALUE CODES AMOUNT										42										43										44										45										46										47										48										49																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																							
42 REV. CD.										43 DESCRIPTION										44 HCPCS / RATE / HIPPS CODE										45 SERV. DATE										46 SERV. UNITS										47 TOTAL CHARGES										48 NON-COVERED CHARGES										49																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																					
1										2										3										4										5										6										7										8										9										10										11										12										13										14										15										16										17										18										19										20										21										22										23																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																															
2										3										4										5										6										7										8										9										10										11										12										13										14										15										16										17										18										19										20										21										22										23																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																									
3										4										5										6										7										8										9										10										11										12										13										14										15										16										17										18										19										20										21										22										23																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																			
4										5										6										7										8										9										10										11										12										13										14										15										16										17										18										19										20										21										22										23																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																													
5										6										7										8										9										10										11										12										13										14										15										16										17										18										19										20										21										22										23																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																							
6										7										8										9										10										11										12										13										14										15										16										17										18										19										20										21										22										23																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																	
7										8										9										10										11										12										13										14										15										16										17										18										19										20										21										22										23																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
8										9										10										11										12										13										14										15										16										17										18										19										20										21										22										23																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																					
9										10										11										12										13										14										15										16										17										18										19										20										21										22										23																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																															
10										11										12										13										14										15										16										17										18										19										20										21										22										23																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																									
11										12										13										14										15										16										17										18										19										20										21										22										23																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																			
12										13										14										15										16										17										18										19										20										21										22										23																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																													
13										14										15										16										17										18										19										20										21										22										23																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																							
14										15										16										17										18										19										20										21										22										23																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																	
15										16										17										18										19										20										21										22										23																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
16										17										18										19										20										21										22										23																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																					
17										18										19										20										21										22										23																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																															
18										19										20										21										22										23																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																									
19										20										21										22										23																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																			
20										21										22										23																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																													
21										22										23																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																							
22										23																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																	
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									
50 PAYER NAME										51 HEALTH PLAN ID										52 REL INFO										53 ASD BEN										54 PRIOR PAYMENTS										55 EST. AMOUNT DUE										56 NPI										57 OTHER										58 INSURED'S NAME										59 P.FEL										60 INSURED'S UNIQUE ID										61 GROUP NAME										62 INSURANCE GROUP NO.																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																			
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																																																																																																																																																																																																																																																																																																																																																																							
63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER										65 EMPLOYER NAME										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																																																																																																																																																																																																																																																																																																																																																																																																																									
69 ADMIT DX										70 PATIENT REASON DX										71 PPS CODE										72 EQ										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																																																																																																																																																																																																																																																																																																																																																																																																																																																																																					
74 PRINCIPAL PROCEDURE DATE										a. OTHER PROCEDURE DATE										b. OTHER PROCEDURE DATE										c. OTHER PROCEDURE DATE										75										76 ATTENDING NPI										QUAL										77 OPERATING NPI										QUAL										78 OTHER NPI										QUAL										79 OTHER NPI										QUAL										80 REMARKS										81CC a										b										c										d										82										83										84										85										86										87										88										89										90										91										92										93										94										95										96										97										98										99										100																																																																																																																																																																																																																																																																																																																																																																																																																																			
80										81										82										83										84										85										86										87										88										89										90										91										92										93										94										95										96										97										98										99										100																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																			

UB-04 CMS-1450 APPROVED OMB NO. NUBC National Uniform Billing Committee LIC9213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

## [Timely Filing](#)

### Timely Filing for Claims

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

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

***Claims submitted after the timely filing period expires will be denied, unless proof of timely filing can be demonstrated according to the guideline listed below.***

### Proof of Timely Filing

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

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

#### ***Acceptable documentation includes the following:***

1. A copy of the claim with a **computer-printed filing date** (a handwritten date isn't acceptable)
2. An original fax confirmation specifying the claim in question and including the following information: date of service, amount billed, member name, original date filed with Anthem and description of the service
3. The provider's billing system printout showing the following information: date of service, amount billed, member name, original date filed with Anthem and description of the service

If the provider doesn't have an electronic billing system, approved documentation is a copy of the member's chart indicating the billed date and/or a copy of the billing records indicating the billed date, and the information listed above.

4. If the claim was originally filed electronically, a copy of Anthem's electronic Level 2 or your respective clearinghouse's acceptance/rejection claims report is required; a copy can be obtained from the provider's EDI vendor, EDI representative or clearinghouse representative. The provider also must demonstrate that the claim and the member's name are on the original acceptance/rejection report. Note: When referencing the acceptance/reject

report, the claim must show as accepted to qualify for proof of timely filing. Any rejected claims must be corrected and resubmitted within the timely filing period.

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

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

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

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

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

#### [Medical Records Submission \(Solicited and Unsolicited\)](#)

##### **Solicited Medical Records Submission**

When additional medical records are being submitted in response to Anthem's 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 **on 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 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.
  - Medical Records requested (solicited) by Anthem needed for Claim processing can be submitted electronically using the Medical Attachments feature on the Availity Portal. The *solicited* Medical Attachments feature supports .tiff, .jpg and .pdf attachment file types. To access the *solicited* Medical Attachments tool, a provider organization's Availity administrator should complete the following steps:

From **My Account Dashboard**, select **Enrollments Center > Medical Attachments Setup**, follow the prompts and complete the following sections:

1. Select Application > Choose **Medical Attachments Registration**
  2. Provider Management > Select **Organization** from the drop-down.
    - Add NPIs and/or Tax IDs.
    - Multiples can be added separated by spaces or semi-colons.
  3. Assign user access by checking the box in front of the user's name. Users may be removed by unchecking their name.
- To use the *solicited* Medical Attachments tool, Availity users should complete the following steps:
1. Log in to [www.availity.com](http://www.availity.com).
  2. Select **Claims and Payments > Medical Attachments > Send Attachment** tab.
  3. Complete all required fields on the form.
  4. Attach supporting documentation.

## Unsolicited Medical Records Submission

Anthem will send a request when medical records are required. However, if a Provider or Facility wishes to send medical records with the Claim submission, below are helpful tips to follow.

To determine what medical records or portion of the medical records may be required, refer to the applicable Anthem Medical Policy, Anthem Clinical Guideline at [www.anthem.com](http://www.anthem.com) or the applicable AIM Clinical Guideline at <http://aimspecialtyhealth.com/ClinicalGuidelines.html>. Review the Position Statement section in the Anthem Medical Policies, or Clinical Indications section in the applicable Anthem Clinical Guidelines or the appropriate AIM Clinical Guideline, to determine what medical records are needed. Refer the *Medical Policies*, *Clinical Guidelines*, and/or *AIM Specialty Health* sections of the Provider Manual for details on accessing this information.

When submitting medical records that are not requested by Anthem, include a clear description of the billed code submitted with the Claim to help ensure prompt processing of the Claim for all miscellaneous, not otherwise classified (NOC), not otherwise specified (NOS), and unlisted HCPCS and CPT codes.

## Types of Medical Records Required

Medical records needed to determine the medical necessity of a billed code include, depending on the service or procedure, some or all of the following examples:

1. History & Physical, Office Notes, Treatment Records & Response
2. Chemotherapy Regimens, Chemotherapy Drugs, and Records
3. Medications List (current and prior)
4. Radiology, Diagnostic Imaging, or Diagnostic Testing Reports



5. Therapy/Rehabilitation Records
6. Laboratory reports, Pathology reports
7. Exact description of NOC/NOS code
8. Operative/Procedure Report
9. Inpatient Admission Summary, Daily Records, Discharge Summary

### **Anthem May Request Additional Records**

Some situations may require additional medical records in addition to what was submitted with the Claim. Although these situations may not have specific rules and guidelines, Anthem will make every attempt to make these requests explicit and limited to the minimal requests necessary to render a decision. Examples include, but are not limited to, the following situations:

1. Medical records requested by a member's Blue Cross and/or Blue Shield home plan
2. Federal Employee Plan requirements
3. Review and investigation of Claims (e.g., pre-existing conditions [for grandfathered policies of the Affordable Care Act], lifetime benefit exclusions)
4. Medical review and evaluation
5. Requests for retro authorizations
6. Medical management review (utilization review) and evaluation
7. Underwriting review and evaluation
8. Adjustments
9. Appeals
10. Quality management (quality of care concerns)
11. Records documenting prolonged services
12. Provider audits
13. Pre-pay review program
14. Fraud, waste and abuse

### **HIPAA Privacy Rule – Minimum Necessary**

Anthem complies with HIPAA Privacy Rules and will request the minimum necessary information needed to determine benefits and/or coverage associated with Claim processing. Providers and Facilities are also required under the Minimum Necessary rule to submit only those records requested.

### **[Electronic Data Interchange \(“EDI”\) Overview](#)**

Anthem recommends using the Electronic Data Interchange (“EDI”) 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.

Anthem has designated Availity to operate and serve as the electronic data interchange (EDI) Gateway. As a mandatory requirement, all trading partners who currently submit directly to the Anthem EDI Gateway must transition to the Availity EDI Gateway. If Providers and Facilities wish to become a direct trading partner with Availity, the setup is easy. Use the [Availity Welcome Application](#) to begin the process of connecting to the Availity EDI Gateway for Anthem EDI transmissions. If Providers or Facilities prefer to use their clearinghouse or billing company, they must work with them to ensure connectivity through the Availity EDI Gateway.

Submitting via EDI may require additional hardware and software needed to automate other tasks in your office. No matter what method you choose to submit your transactions (direct or through a clearinghouse/billing company), 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 will need to use the Council for Affordable Quality Health Care (CAQH) Enrollment Tool called [EnrollHub](#) (at <https://solutions.caqh.org/>), a secure electronic 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 EFT will register with CAQH’s EnrollHub to manage account changes, but otherwise do not need to take action.

### **Electronic Remittance Advice (“ERA”)**

Effective June 1, 2018, Providers and Facilities must use Availity to manage all account changes and new registrations for ERA transactions.

### **Additional Information**

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

### **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
- Coordination of Benefits
- Late credits

- Billed in error
- Non-covered services
- Terminated Members
- Paid wrong Member/ Provider number
- 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 from any Claim Provider or Facility submits to Anthem.

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 Refund Adjustment Request Form** with supporting documentation to have claim adjustment/recoupment done off a future remittance advice

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

- **Provider Refund Adjustment Request Form (see directions below 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 Refund Adjustment Request Form online:

To download the "Provider Refund Adjustment Request Form" directly from **anthem.com**, and select **Providers**. Under the *Provider Resources* heading, select **Forms**, and pick your state. Then select [Provider Refund Adjustment Request Form](#).

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

Line of Business (Blue Branded)	Type of Refund	Make Check Payable To:	Regular Mailing Address:	Overnight Delivery Address:
Individual Health Insurance Exchange, Private Health Insurance Exchange	Voluntary	Anthem Blue Cross and Blue Shield	Anthem Blue Cross and Blue Shield PO Box 73651 Cleveland, OH 44193-1177	Anthem Attn: Central - 73651 4100 W 150th Street Cleveland, OH 44135-1304
Individual Health Insurance Exchange, Private Health Insurance Exchange	Solicited Refund with Payment Coupon	Anthem Blue Cross and Blue Shield	Anthem Blue Cross and Blue Shield PO Box 5281 Carol Stream, IL 60197	N/A
BlueCard, National	Voluntary & Solicited Refund with Payment Coupon	Anthem Blue Cross and Blue Shield	Anthem Blue Cross and Blue Shield PO Box 73651 Cleveland, OH 44193-1177	Anthem Attn: Central - 73651 4100 W 150th Street Cleveland, OH 44135-1304

## 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 Providers 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 the 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 [anthem.com](https://www.anthem.com).
- Please contact your local Anthem Plan.



---

## Claim Action Request Procedures

### [When to Submit a Claim Action Request](#)

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

Please reference the **Claim Payment Disputes** section if you are disputing a claim once the claim has been processed through finalization, and the claim appears as paid or denied on your EOB/RA. (Note: For Medicare/Medicaid claims only).

**Please note:** Please direct claim status inquiries through Availity, our interactive voice response (“IVR”) system, or to provider customer service. Sending claim status inquiries via a Claim Action Request Form will delay the response to your inquiry.

### [How to Submit a Claim Action Request](#)

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

### **How to Obtain a Claim Action Request**

This form is available in electronic format for typing your information.

Go to **anthem.com**, and select **Providers**. Under the *Provider Resources* heading, select **Forms and Guides**. Search for [Claim Action Request Form](#). Select **Colorado** if you haven’t done so already.

### [Where to Send Completed Claim Action Request](#)

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

Anthem Blue Cross and Blue Shield  
P.O. Box 5747  
Denver, CO 80217-5747

For Federal Employee Program (FEP) members (prefix R + 8 numerics):

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

### [Who to Contact with Questions about Claim Action Requests](#)

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

---

## **Provider Complaint and Dispute Resolution (Appeals) Process**

### [Provider Dispute Resolution \(Appeals\)](#)

#### **Policy Statement**

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

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

Anthem shall make a determination of a provider dispute resolution request within forty-five (45) calendar days of receipt of all necessary information. When Anthem does not receive all necessary information to make a decision, Anthem shall request in writing within thirty (30) calendar days of receipt of the request the additional information needed. Anthem shall allow thirty (30) calendar days from the date of the request to

receive the requested information. If the provider does not respond within the thirty (30) calendar day timeframe, Anthem shall close the request without further review. Further consideration of the closed provider dispute resolution request must begin with a new request by the provider.

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

### **Necessary Information**

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

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

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

### **Notification Requirements**

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

- a. A description of the carrier's dispute resolution procedures and timeframes;
- b. The procedures and timeframes for the provider or the provider's representative to present his rationale for the dispute resolution request; and

- c. The date by which the carrier must resolve the dispute resolution request.

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

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

- a. A description of the additional necessary information required to process the request;
- b. The date that additional information must be provided by the provider; and
- c. A statement that failure to provide the requested information within thirty (30) calendar days from the carrier's request for additional information will result in the closure of the request with no further review.

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

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

- a. The names and titles of the parties evaluating the provider-carrier dispute resolution request, and where the decision was based on a review of medical documentation, the qualifying credentials of the parties evaluating the provider-carrier dispute resolution request;
- b. A statement of the reviewers' understanding of the reason for the provider's dispute;
- c. The reviewers' decision in clear terms and the rationale for the carrier's decision; and
- d. A reference to the evidence or documentation used as the basis for the decision.

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

## [Provider Dispute Resolution Form](#)

This form is available in electronic format for typing your information.

Go to **anthem.com**, and select **Providers**. Under the *Claims* heading, select [Provider Appeals](#). Select **Colorado** if you haven't done so already.

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

- **For Local Plan members and BlueCard members (all three-character prefixes other than R + 8 numerics):**

Anthem Blue Cross and Blue Shield  
P.O. Box 5747  
Denver, CO 80217-5747

- **For Federal Employee Program (FEP) members (prefix R + 8 numerics):**

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

---

## Member Grievance and Appeal Process

### [Member Appeals](#)

#### Complaints and appeals

Anthem may have turned down your claim. We may have also denied your request to preauthorize or receive a service or a supply. If you disagree with Anthem's decision you can:

- 1) start a complaint
- 2) file an appeal or
- 3) file a grievance.

#### Complaints

If you want to start a complaint about Anthem's customer service or how we processed your claim, please call customer service. A trained staff member will try to clear up any confusion about the matter. They will also try to resolve your complaint. If you prefer, you can send a written complaint to this address:

Anthem Blue Cross and Blue Shield  
Customer Service Department  
P.O. Box 5747  
Denver, CO 80217-5747

If your complaint isn't solved either by writing or calling, or if you don't want to file a complaint, you can file an appeal. We'll tell you how to do that next, in the Appeals section.

## **Appeals**

It's best to file your appeal within 60 days of getting a denial. The absolute cut-off date for filing an appeal is 180 days from the day you were denied. You can appeal denials that were made either before you received service or after you received service. You can send an appeal in writing to:

Anthem Blue Cross and Blue Shield  
Attn: Member Appeals Department  
700 Broadway  
Denver, CO 80273-0001

You don't have to start a complaint before you file an appeal. In your appeal, please state as plainly as possible why you think we shouldn't have denied your claim. Include any documents you didn't submit with the original claim or service/supply request. Also send any other document or documents that support your appeal.

To make sure you get a thorough, unbiased appeal, there are two levels of appeal. Also, if your claim was denied because of utilization review, you may request independent external review.

You don't have to file the appeal yourself. Someone else, like your doctor, can file any level of appeal for you. Just let us know in writing who will be filing the appeal for you.

### **Level 1 appeal**

A Level 1 appeal will be reviewed by a person, who may be on our staff, but who wasn't involved in the denial. They may get information from co-workers or others who did make the decision. Where the decision is based on utilization review, the Level 1 appeal will involve a review by (or a discussion with) a person in the same medical specialty as the case being reviewed.

Unless you ask for or agree to a longer period, you'll get an answer to your appeal within 30 days from when we got your appeal request. But for appeals of services that were already performed, and which did not involve a denial based on utilization review, we'll answer the appeal in 60 days.

## **Level 2 appeal**

If Anthem turned down your appeal at Level 1 you have the choice to continue to a Level 2 appeal. You have 60 days from our Level 1 decision to ask for a Level 2 appeal.

A Level 2 appeal gives you the chance to supply documents or information at an appeal hearing. You can do this in a couple of ways. You can come in person or you can use a teleconference. You are encouraged to bring information, testimony, witnesses or other evidence that supports your appeal.

There will be at least three people who review your appeal. They could be Anthem employees. People who worked on your claim may present information, answer questions, or review the appeal. But a majority of the reviewers will not have worked on your claim before.

If your case involves utilization review, the people reviewing your appeal will be health care professionals. All reviewers:

Will have appropriate expertise

Will not have been previously involved in your case; and

Will not be on our board of directors.

Will not have a direct financial interest in the case or in the decision.

Anthem will give you a copy of the written decision. We'll also give a copy to any provider who may have represented you in the appeal. You'll get the copy within 60 days from the day we got your Level 2 request, unless you ask for or agree to a longer period.

## **Expedited appeals**

You or your representative can ask for an expedited appeal if you had emergency services but haven't been discharged from the facility. Also, you can ask for an expedited appeal if the regular appeal schedule would do one of the following:

Seriously jeopardize your life or health;

Jeopardize your ability to regain maximum function;

Create an immediate and substantial limitation on your ability to live independently, if you're disabled; or

In the opinion of a physician with knowledge of your condition, would subject you to severe pain that can't be adequately managed without the service in question.

But expedited appeals are not available for denials made after the service has been provided.

Your request doesn't have to be in writing and can be made orally. We'll try to make the decision as soon as we can. But it won't take more than 72 hours. The reviewers won't be the people who denied your claim before. If you don't agree with the appeal decision, you can either continue to a Level 2 appeal, or request independent external review.

## **Independent external review appeals**

For claims based on utilization review, you can request an independent external review appeal. For these appeals, your case is reviewed by an external review entity, selected by the Colorado Division of Insurance.

If you want to request an independent external review, you have to fill out a form. It's called the Request for Independent External Review of Carrier's Final Adverse Determination Form. (Your representative can fill it out for you too.) You can get the form from Anthem's customer service department. Once it's filled out, you need to send it to us.

You can ask for an independent external review within 4 months of your receipt of our Level 1 appeal decision, or within 60 days from receipt of the Level 2 appeal decision, or if we fail to complete the Level 1 appeal in the timeframes mentioned above.

## **Expedited independent external review appeals**

You can request an expedited independent external review, but only if your case meets certain criteria. You will need a physician to certify to us that you have a medical condition where following the normal external review appeal process would seriously jeopardize your life or health, would jeopardize your ability to regain maximum function or, if you are disabled, would create an imminent and substantial limitation of your ability to live independently. If it meets these conditions, your request can be filed at the same time as your request for a Level 1 Appeal. Use the external review request form to request an expedited review. An expedited appeal may not be allowed for denials made after service was provided.

## **Grievances**

You may send a written grievance to:

Anthem Blue Cross and Blue Shield  
Quality Management Department  
700 Broadway MC 0532  
Denver, CO 80273

Anthem's Member Grievances Department will acknowledge that we've received your grievance. They'll also investigate it. We treat every grievance confidentially.

## **Division of Insurance inquiries**

If you have a question about health care coverage in Colorado, please call the Division of Insurance at (303) 894-7490. Representatives will speak with you Monday through Friday, from 8:00 a.m. to 5:00 p.m. You can also write to:



The Division of Insurance  
Attention ICARE Section  
560 Broadway, Suite 850  
Denver, Colorado 80202

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

### [How a Member can Obtain Language Assistance](#)

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

---

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

### [Overview](#)

The Grievances and Appeals (“G&A”) department develops, maintains and implements policies and procedures for identifying, reporting and evaluating potential quality of care/service (“QOC” / “QOS”) concerns or sentinel events involving Anthem 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.

Providers and Facilities have a contractual obligation to actively cooperate with any investigation. When a Member alerts Anthem to a quality concern regarding the care they received, Anthem has an obligation to thoroughly investigate that allegation by reviewing all relevant materials including any internal investigation and their outcomes done by the impacted Providers and/or Facility. This requirement is in the Provider and Facility Agreements and, as a business associate, Anthem has a right to that information.

### 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	10	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.***

---

## Reimbursement Guidelines and Policies

This section includes reimbursement guidelines and policies on how Anthem will reimburse Providers and Facilities for certain services. Additional Professional and Facility Reimbursement Policies are published on anthem.com be sure to check both places. Anthem reserves the right to review and revise policies when necessary.

[Reimbursement Policies are available online](#)

Go to [anthem.com](https://www.anthem.com), select **Providers**. Select **Find Resources for Your State**, and pick **Colorado**. Under the *Provider Resources* heading, select **Policies, Guidelines, and Manuals**. Under the *Reimbursement Policies* heading, select [Access Policies](#). Then search for the Policy you would like to view. They are listed in alpha order, and can be filtered by category such as, Coding, DME, Drugs, E&M, Facilities, Labroary, Medicare Advantage, etc.

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

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

### [Changes During Admission](#)

There are 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 Contracted Rate (other than DRG)	Admission
DRG Base Rate	Admission
DRG Grouper	Discharge
DRG Relative Weight	Discharge

DRG Grouper Version / DRG Relative Weight changes can occur any time after October 1<sup>st</sup> each year.

### [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 Anthem, 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.

### 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 reimbursable. Examples of daily supplies include those commonly used services and supplies provided in relatively equal quantities to all patients in similar circumstances. It also includes those inexpensive supplies and medications for which it is uneconomical to account separately.

### Different Settings Charges

If Anthem determines that Facility submits charges differently for the same service performed in a different setting, Anthem will reimburse at the Anthem Rate for the lesser of the two charges.

### Eligibility and Payment

A guarantee of eligibility is not a guarantee of payment.

### Emergency Room Supply and Services Charges

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

### Facility Personnel Charges

Charges for Inpatient Services for Facility personnel are not separately reimbursable and the reimbursement for such is included in the room and board rate. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions (including IV or PICC line insertion at bedside), professional therapy functions, including Physical, Occupational, and Speech (typically billed in Revenue Codes 976, 977, 978 and 979), call back charges, nursing increments, therapy increments, and bedside respiratory and pulmonary function services (typically billed in Revenue Codes 410-419, 460 and 469). Outpatient Services for Facility personnel are also not separately reimbursable. Reimbursement is included in the reimbursement for the procedure or observation charge.

## General Industry Standard Language

Per Anthem policy and the Agreement, Provider and Facility will follow industry standards related to billing. Examples of general industry standards include, but are not limited to, HCPCS, ICD10/CM, health service codes (also known as Revenue Codes) per the UB-04 Claim billing manual or subsequent forms CPT codes.

## 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, and Anthem shall not reimburse Facility for implants that are deemed contaminated and/or considered waste and/or were not implanted in the Member. Anthem also requires an itemization of all implant kits that contain procedure tools or medical supplies. If an implant is supplied during the inpatient stay or outpatient procedure as part of a kit, then the implant will be the only component of the kit that shall be reimbursed by Anthem.

## Instrument Trays

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

## Interim Bill Claims

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

## IV Sedation and local anesthesia

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



### Lab Charges

Venipuncture, specimen collection, draw fees, phlebotomy, heel stick, processing fees, handling fees, blood storage and processing, blood administration. These charges are inclusive of the procedure/lab test performed and not separately billable.

### Labor Care Charges

Anthem 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.

### Neuromonitoring (technical component)

Effective for claims with dates of service on or after March 15, 2015, Anthem will consider the technical component for neuromonitoring services performed in an operating room setting to be all inclusive to the facility reimbursement rate.

Therefore, claims submitted by anyone other than the rendering facility will not be eligible for separate or additional reimbursement. If the rendering facility utilizes a neuromonitoring vendor to perform any services, then it is the rendering facility's responsibility to reimburse the vendor directly. Any claims submitted to Anthem for these additional services will be denied as they will be considered part of the all-inclusive facility reimbursement.

### Non-Participating Provider Claims Payment

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 rather than the non-participating provider.



## Nursing Procedures

Anthem 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.)

## Operating Room Time and Procedure Charges

The operating room ("OR") 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 OR nurse's notes. The operating room charge will reflect the cost of:

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

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

The operating room charge will not reflect the cost of robotic technology and is not eligible for separate reimbursement. Examples of charges that are not eligible for separate or additional reimbursement 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 reimbursable. Examples include but are not limited to: breast pumps, deodorant, dry bath, dry shampoo, lotion, non-medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, toothbrush and toothpaste. Items used for the patient which are needed as a direct result of a procedure or test are considered part of the room and board or procedure charges and are not separately reimbursable or billable to the patient. Examples include but are not limited to: bedpans, chux, hot water bottles, icepacks, pillows, sitz baths, and urinals.

### Pharmacy Charges

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

### Portable Charges

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

### Pre-Operative Care or Holding Room Charges

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

### Preparation (Set-Up) Charges

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

## Preventable Adverse Events (“PAEs”) (Facility Reimbursement Policy)

### **Acute Care General Hospitals (Inpatient)**

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

When any of the Preventable Adverse Events (“PAEs”) set forth in the grid below occur with respect to a Member, the acute care general hospital shall neither bill, nor seek to collect from, nor accept any payment from the Plan **or** the Member for such events. If acute care general hospital receives any payment from the 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.

<b>Preventable Adverse Event</b>	<b>Definition / Details</b>
<b>1. Surgery Performed on the Wrong Body Part</b>	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.
<b>2. Surgery Performed on the Wrong Patient</b>	Any surgery on a patient that is not consistent with the documented informed consent for that patient. Surgery includes endoscopies and other invasive procedures.
<b>3. Wrong surgical procedure performed on a patient</b>	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 Plan for payment. In no event shall the charges or days associated with the HAC be billed to either the Plan or the Member.

### **Providers and Facilities (excluding Inpatient Acute Care General Hospitals)**

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

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

<b>Preventable Adverse Event</b>	<b>Definition / Details</b>
<b>1. Surgery Performed on the Wrong Body Part</b>	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.
<b>2. Surgery Performed on the Wrong Patient</b>	Any surgery on a patient that is not consistent with the documented informed consent for that patient. Surgery includes endoscopies and other invasive procedures.
<b>3. Wrong surgical procedure performed on a patient</b>	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.

Preventable Adverse Event	Definition / Details
<b>4. Retention of a foreign object in a patient after surgery or other procedure</b>	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 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 has created levels of care for this service category. These levels differ in terms of the degree of services required, as defined by the combination of ICD-10 diagnosis codes and revenue codes.

#### Level 1

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

#### Level 2

This includes partial hospitalization (six to eight (6-8) 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 diagnosis codes must be included for each care level.
2. Revenue Codes must be included for each care level. Appropriate Revenue Codes are 0901, 0911-0914, 0944 or 0945.

3. Utilization management must approve the level of care for all services. An authorization number is required for each Claim.
4. Each service date must be billed as a separate line item.

### Recovery Room Charges

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

### Recovery Room Services related to IV sedation and/or local anesthesia

Anthem will not provide reimbursement for a phase I or primary recovery room charged in connection with IV sedation or local anesthesia. Charges will be paid only if billed as a post procedure room or a phase II recovery (step-down) e.g. arteriograms. The Anthem Rate shall not exceed the Facility's approved average semi-private room and board rate less discount, as submitted to Anthem.

### Routine Supplies

Any supplies, items and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately billable in the inpatient and outpatient environments.

All items and supplies that may be purchased over-the-counter are not separately billable.

All reusable items, supplies and equipment that are provided to all patients during an inpatient or outpatient admission are not separately billable.

All reusable items, supplies and equipment that are provided to all patients admitted to a given treatment area or unit (i.e., NICU, Burn Unit, PACU, Medical/Surgical Unit), as well as all reusable items, supplies and equipment that are provided to all patients receiving the same service (i.e., an Ambu bag during resuscitation), are not separately reimbursable.

### Semi Private Room Rate

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

the approved average semi-private room and board rate, less discount, as submitted to Anthem.

### Special Procedure Room Charge

Special procedure room charges are included in the reimbursement for the procedure. If the procedure takes place outside of the OR suite, then OR time cannot be billed separately to cover OR personnel/staff being present in the room. Example: ICU, GI lab, etc.

### Stand-by Charges

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

### Stat Charges

Stat charges are included in the reimbursement for the procedure, test and or X-ray. These charges are not separately reimbursable.

### Submission of Claim/Encounter Data

Facility agrees to submit HMO Claims and encounter data to Anthem on a CMS 1500, UB-04 or successor form, in a manner consistent with industry standards and Anthem policies and procedures as approved by Anthem. Facility agrees to submit Traditional and PPO Claims to Anthem for payment on a CMS 1500, UB-04 or successor form, in a manner consistent with industry standards and Plan policies and procedures as approved by Anthem. Plan agrees to make best efforts to pay all Complete Claims for Covered Services submitted by Facility 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 Anthem's payment liability, if any, because of issues such as coordination of benefits, subrogation or verification of coverage. Anthem agrees to make such determinations within a reasonable period of time and to cooperate with Facility, upon request, in good faith and within reason, in creating and maintaining methods and procedures to allow Anthem to efficiently identify Covered Services.

### Supplies and Equipment

Charges for medical equipment, including but not limited to, IV pumps, PCA Pumps, and isolation carts and supplies are not separately reimbursable. Also, oxygen charges, including but not limited to, oxygen per minute, per hour and therapy, when billed with room types ICU/CCU or any Specialty Care area, where equipment is a requirement to be authorized for specialty category, are not separately reimbursable.

### Tech Support Charges

Pharmacy Administrative Fees (including mixing medications), any portable fees for a procedure or service, patient transportation fees when taking a patient to an area for a procedure or test are not separately reimbursable. Transporting a patient back to their room following surgery, a procedure, or test, are not separately reimbursable.

### Telemetry

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

### 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.



Unless the Provider or Facility Agreement with Anthem specifies a different timeframe, pre-admission/pre-surgical/ pre-operative testing that occurs within seven two (72) days prior to the inpatient admission or outpatient procedure will be included in the DRG Rate, Per Diem Rate, Case Rate or any other Anthem Rate for Covered Services, and shall not be billed or paid separately. All Claims billed separately for these services must be accompanied with the appropriate ICD-10 codes.

### Time Calculation

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

### Unapproved Rate Changes

Facility must provide written notification regarding any planned rate changes. The notification will supply all data necessary for Anthem to evaluate the impact of the change in rate on Claims processing for Covered Services. Rate increases that are not approved by Anthem are recoverable through a refund request or a reduction in future Claims payment.

Facility payment levels will be reviewed on an annual basis if requested by Facility. The following steps are to be followed:

1. Contact your network manager for all notifications of rate changes.
2. Proposed increases in inpatient and/or outpatient charges will require documentation necessary to verify the amount of increase being implemented within each department of the Facility.
3. In addition, a complete electronic charge compendium must be submitted.

Upon receipt of Facility's notification of a change in their charges, Anthem's review may include, but is not limited to the following items:

- a) Facility specific Anthem Rate versus the Anthem Rate in the market (market rate is the weighted average of Anthem Rates for a particular service area).
- b) The percentage increase being implemented in Facility's charges.
- c) Contractual maximum.
- d) Previously negotiated changes to the Anthem Rate.
- e) The length or term of the previous Agreement and proposed Agreement.
- f) The potential impact to premium pricing versus cost of care trends.
- g) Reasoning and or documentation behind the specific rate change request.
- h) Information detailing how changes are distributed between inpatient and outpatient services and specifically within each Facility department.

### Undocumented or Unsupported Charges

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

### Video Equipment used in Operating Room

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

### Additional Reimbursement Guidelines for Disallowed Charges

Only Charges for Covered Services are eligible for reimbursement. The disallowed charges (charges not eligible for reimbursement) include, **but are not limited to**, the following, whether billed under the specified Revenue Code or any other Revenue Code.

The tables below illustrate examples of non-reimbursable revenue codes:

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
0990 – 0999	Personal Care Items <ul style="list-style-type: none"><li>• Courtesy/Hospitality Room</li><li>• Patient Convenience Items (0990)</li><li>• Cafeteria, Guest Tray (0991)</li><li>• Private Linen Service (0992)</li><li>• Telephone, Telegraph (0993)</li><li>• TV, Radio (0994)</li><li>• Non-patient Room Rentals (0995)</li><li>• Beauty Shop, Barber (0998)</li><li>• Other Patient Convenience Items (0999)</li></ul>
0220	Special Charges
0369	Preoperative Care or Holding Room Charges
0760 – 0769	Special Procedure Room Charge
0111 – 0119	Private Room* (subject to Member's Benefit)
0221	Admission Charge
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) Stand-by Charges
0220, 0949	Stat Charges
0270 – 0279, 0360	Video Equipment Used in Operating Room
0270, 0271, 0272	<b>Supplies and Equipment</b> <ul style="list-style-type: none"><li>• Blood Pressure cuffs/Stethoscopes</li></ul>

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
	<ul style="list-style-type: none"> <li>• Thermometers, Temperature Probes, etc.</li> <li>• Pacing Cables/Wires/Probes</li> <li>• Pressure/Pump Transducers</li> <li>• Transducer Kits/Packs</li> <li>• SCD Sleeves/Compression Sleeves/Ted Hose;</li> <li>• Oximeter Sensors/Probes/Covers</li> <li>• Electrodes, Electrode Cables/Wires</li> <li>• Oral swabs/toothettes;</li> <li>• Wipes (baby, cleansing, etc.)</li> <li>• Bedpans/Urinals</li> <li>• Bed Scales/Alarms</li> <li>• Specialty Beds</li> <li>• Foley/Straight Catheters, Urometers/Leg Bags/Tubing</li> <li>• Specimen traps/containers/kits;</li> <li>• Tourniquets;</li> <li>• Syringes/Needles/Lancets/Butterflies</li> <li>• Isolation carts/supplies;</li> <li>• Dressing Change Trays/Packs/Kits</li> <li>• Dressings/Gauze/Sponges;</li> <li>• Kerlix/Tegaderm/OpSite/Telfa</li> <li>• Skin cleansers/preps;</li> <li>• Cotton Balls; Band-Aids, Tape, Q-Tips</li> <li>• Diapers/Chucks/Pads/Briefs</li> <li>• Irrigation Solutions</li> <li>• ID/Allergy bracelets;</li> <li>• Foley stat lock;</li> <li>• Gloves/Gowns/Drapes/Covers/Blankets;</li> <li>• Ice Packs/Heating Pads/Water Bottles</li> <li>• Kits/Packs (Gowns, Towels and Drapes);</li> <li>• Basins/basin sets;</li> <li>• Positioning Aides/Wedges/Pillows;</li> <li>• Suction Canisters/Tubing/Tips/Catheters/Liners</li> <li>• Enteral/Parenteral Feeding Supplies (tubing/bags/sets, etc.)</li> </ul>

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
	<ul style="list-style-type: none"> <li>• Preps/prep trays;</li> <li>• Masks (including CPAP and Nasal Cannulas/Prongs);</li> <li>• Bonnets/Hats/Hoods;</li> <li>• Smoke Evacuator Tubing;</li> <li>• Restraints/Posey Belts</li> <li>• OR Equipment (saws, skin staplers, staples &amp; staple removers, sutures, scalpels, blades etc.)</li> <li>• IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets, transducers, fluid warmers, etc.);</li> </ul>
0220 – 0222, 0229, 0250	Tech Support Charges <ul style="list-style-type: none"> <li>• Pharmacy Administrative Fee (including mixing meds)</li> <li>• Portable Fee (cannot charge portable fee unless equipment is brought in from another Facility)</li> <li>• Patient transport fees</li> </ul>
0223	Utilization Review Service Charges
263	IV Infusion for therapy, prophylaxis (96365, 96366); IV Infusion additional for therapy: IV Infusion concurrent for therapy (96368); IV Injection (96374, 96379)
0229, 0760 – 0762, 0769, 0270, 410 – 413, 0419	Other Special Charges <ul style="list-style-type: none"> <li>• Observations hours may never exceed the charge of a semiprivate room charge</li> <li>• Oxygen charges while a patient is on a ventilator</li> <li>• Respiratory assessment/vent management charges</li> </ul>

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310	Nursing Procedures and 99001 – Handling and/or conveyance of specimen from patient (charge for specimen handling)
0230	Incremental Nursing – General
0231	Nursing Charge – Nursery
0232	Nursing Charge – Obstetrics (OB)
0233	Nursing Charge – Intensive Care Unit (ICU)
0234	Nursing Charge – Cardiac Care Unit (CCU)
0235	Nursing Charge – Hospice
0239	Nursing Charge – Emergency Room (ER) or Post Anesthesia Care Unit (PACU) or Operating Room (OR)
0250 – 0259, 0636	Pharmacy (non-formulary drugs, compounding fees, nonspecific descriptions) <ul style="list-style-type: none"> <li>• Medication prep</li> <li>• Nonspecific descriptions</li> <li>• Anesthesia Gases – Billed in conjunction with Anesthesia Time Charges</li> <li>• IV Solutions 250 cc or less</li> <li>• Miscellaneous Descriptions</li> <li>• Non-FDA Approved Medications</li> </ul>
0256	Experimental Drugs
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	Venipuncture (CPT Code 36415, 36416 or G0001) <ul style="list-style-type: none"> <li>• Specimen collection</li> <li>• Draw fees</li> <li>• Phlebotomy</li> <li>• Heel stick</li> <li>• Blood storage and processing blood administration (Rev codes 0380, 0390 – 0392; 0399)</li> </ul>

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
	<ul style="list-style-type: none"> <li>• Thawing/Pooling Fees</li> </ul>
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0410, 0460	<b>Supplies and Equipment</b> <ul style="list-style-type: none"> <li>• Preparation (Set-up) Charges; Set-up is included in the fee for the procedure and, as such, included in the room and board</li> <li>• Oxygen (ICU/CCU/Progressive) O.R., ER and Recovery</li> <li>• Instrument Trays and/or Surgical Packs</li> <li>• Drills/Saws (All power equipment used in O.R.)</li> <li>• Drill Bits</li> <li>• Blades</li> <li>• IV pumps and PCA (Patient Controlled Analgesia) pumps</li> <li>• Isolation supplies</li> <li>• Daily Floor Supply Charges</li> <li>• X-ray Aprons/Shields</li> <li>• Blood Pressure Monitor</li> <li>• Beds/Mattress</li> <li>• Patient Lifts/Slings</li> <li>• Restraints</li> <li>• Transfer Belt</li> <li>• Bair Hugger Machine/Blankets</li> <li>• SCD Pumps</li> <li>• Heal/Elbow Protector</li> <li>• Burrs</li> <li>• Cardiac Monitor</li> <li>• EKG Electrodes</li> <li>• Vent Circuit</li> <li>• Suction Supplies for Vent Patient</li> <li>• Electrocautery Grounding Pad</li> <li>• Bovie Tips/Electrodes</li> <li>• Anesthesia Supplies When Billed with Anesthesia Time Charges</li> <li>• Anesthesia Circuit</li> <li>• Perfusion Supplies When Billed with Perfusionist Time Charge</li> </ul>

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
	<ul style="list-style-type: none"> <li>• Case Carts</li> <li>• C-Arm/Fluoroscopic Charge</li> <li>• Wound Vacuum Pump</li> <li>• Bovie/Electro Cautery Unit</li> <li>• Wall Suction</li> <li>• Retractors</li> <li>• Single Instruments</li> <li>• Oximeter Monitor</li> <li>• CPM Machines</li> <li>• Lasers</li> <li>• Davinic Machine/Robot</li> </ul>
0309 – 0369, 0419, 0619	After Hours – Call-back
0370 – 0379, 0410, 0460, 0480 – 0489	Anesthesia (Specifically, conscious/moderate sedation) <ul style="list-style-type: none"> <li>• Nursing care</li> <li>• Monitoring</li> <li>• Intervention</li> <li>• Pre- or Post-evaluation and education</li> <li>• IV sedation and local anesthesia</li> <li>• Intubation/Extubation</li> <li>• CPR</li> </ul>
410	Nursing/Respiratory Functions: <ul style="list-style-type: none"> <li>• Oximetry (94760, 94761, 94762)</li> <li>• Oximetry reading by nurse or respiratory tech</li> <li>• Vent Management</li> <li>• Postural Drainage</li> <li>• Suctioning Procedure</li> <li>• Nursing/Respiratory care performed while patient is on vent</li> </ul>
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) stand-by charges
0940 – 0945	Education/Training



Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
0270, 0272, 0300 – 0309	Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time, glucose, etc.)

Member Responsibility	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
0110 – 0119	Private Room*
0990	Patient Convenience Items
0991	Cafeteria, Guest Tray
0992	Private Linen Service
0993	Telephone, Telegraph
0994	TV, Radio
0995	Non-patient Room Rentals
0996	Late Discharge
0998	Beauty Shop, Barber
0999	Other Patient Convenience Items

\* Subject to the Member's Benefit Agreement.

### Copayments/Cost Shares

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

### *Office Visit Copayments*

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

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

### *Emergency/Urgent Care Copayment*

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

The **urgent care** copayment is collected when a member is seen at an urgent care center. These amounts are listed on the member's health plan ID card.

### *Inpatient Hospital Copayment*

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

### **Member's Liability**

The only charges for which the Member may be liable, and may be billed by Facility, are the following items:

1. Facility services not covered by the Member's Benefit Agreement. However, for health services that are not Medically Necessary or are experimental/investigational refer to Number 3 below.
2. Copayments, coinsurance and deductible amounts required by the Member's Benefit Agreement, as long as Customer Service has been contacted to verify the Member's responsibility (i.e., whether or not the Member has satisfied his or her respective deductible).
3. Health services that are not Medically Necessary, but agreed to by the Member in advance, in writing, on a waiver form [also called the Member (Patient) Responsibility Agreement] approved by Anthem, which informs the Member that the services are likely not to be deemed Medically Necessary or are likely to be

non-covered due to being experimental or investigational, and which includes an estimate of the cost of the services to which the Member is agreeing to pay. A sample of the Member (Patient) Responsibility Agreement can be found in the Exhibits section of this Manual.

The Facility may not charge the Member for upgrades on durable medical equipment (DME) or other services generally not covered under the Member's Benefit Agreement, unless the Member has agreed to cover such upgrades in writing, by signing a waiver form approved by Anthem. The [Member Liability Waiver](#) can be found on anthem.com > **Providers** > under *Provider Resources* heading, select **Forms and Guides** > [Member Liability Waiver](#). This Agreement must be made in advance and with knowledge of Anthem's lack of medical necessity determination. For the waiver form to be valid, the enrollee must sign it.

The waiver form should indicate the full amount the Facility is billing for the service/equipment and the amount the Member has agreed to as his or her responsibility. To avoid processing delays, submit the waiver form with the claim.

Members are not liable for any Stop Loss balances after reaching their benefit maximum.

### **Third-Party Liability**

Occasionally, a Facility may treat a Member for a condition, illness, or injury for which another person or entity may be liable or legally responsible for causing. Under many Anthem Benefit Agreements, Anthem pays the treatment costs associated with such conditions, illnesses or injuries, if they are otherwise covered by the Benefit Agreement.

Anthem may have a right under the Member's Benefit Agreement to seek reimbursement for the benefits it pays for this treatment from a third party or third-party's insurer. However, neither this right to reimbursement nor the fact that Anthem may have been reimbursed, in whole or in part, for a particular benefits payment renders the medical services noncovered under the Member's Agreement.

Under their Agreements with Anthem, Facilities have agreed to accept a negotiated rate as payment in full for services rendered to Anthem Members. Facilities will bill Anthem directly and may look to responsible third parties for certain limited costs (i.e., deductible and copayment amounts). However, Facilities may not look to third parties for any amounts that would exceed the negotiated rate (e.g., the difference between the negotiated rate and the Facility's Total Eligible Billed Charges). In addition, Facilities may not look to the responsible third party for the negotiated rate if Anthem has already issued payment. To do so would result in double compensation to the Facility.

When a third party may be liable, Facilities should notify the Anthem Third-Party Liability department at the toll-free phone number 1-800-645-9785.

---

## **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 that are objective and based on clinical evidence 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 and behavioral health 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. Both set forth position statements or clinical indications regarding the medical necessity of individual services and/or procedures. In general, Medical Policy may be developed to address experimental or investigational technologies (including a novel application of an existing technology) and services where there is a significant concern regarding Member safety. Clinical UM guidelines address Medical Necessity criteria for technologies or services where sufficient clinical evidence exists to evaluate the clinical appropriateness of the request, goal length of stay (GLOS), place of service and level of care. 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**, and then under the *Provider Resources* heading select the **Policies and Guidelines** link. Select **Colorado**. Choose **View Medical Policies and UM Guidelines**, 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 may choose whether to implement a particular clinical UM guideline. The link below can be used to confirm whether the local Plan has adopted the clinical UM guideline(s) in question. Adoption lists are created and maintained solely by each local Plan.

To view the list of specific clinical UM guidelines adopted by Colorado, under the *About These Policies* heading, select [Clinical UM Guidelines adopted by Anthem Blue Cross and Blue Shield in Colorado](#).

---

## **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. Provider or Facility shall comply with all requests for medical information required to complete Anthem’s UM review. Providers and Facilities agree to adhere to the following provisions and provide the information as outlined below within this section.

### **UM Definitions**

1. **Adverse Determination:** means a denial, reduction or failure to make payment (in whole or in part) for a benefit based on a determination that a benefit is experimental, investigational, or not medically necessary or appropriate as defined in the applicable health benefit plan. This may apply to prospective, continued stay, and retrospective reviews.

2. **Business Day:** Monday through Friday, excluding designated company holidays.
3. **Continued Stay Review:** (continuation of services) means utilization review that is conducted during a Member's ongoing stay in a facility or course of treatment. Continued Stay Review includes continuation of services (Urgent Care & Extensions).
4. **Notification:** The telephonic and/or written/electronic communication to the applicable Providers, Facility and the Member documenting the determination, and informing the Member, Providers, and Facility of their rights if they disagree with the determination.
5. **Pre-certification/Pre-authorization Requirements:** List of procedures that require Pre-service Review by Anthem UM prior to service delivery. 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.
6. **Pre-Service (Prospective) Review:** Review for Medical Necessity that is conducted on a health care service or supply prior to its delivery to the Member.
7. **Post-Service (Retrospective) Review:** means a utilization review that is conducted after the health care service (or supply) has been provided to the Member.
8. **Urgent Care Review:** means review of health care services which in the opinion of the treating Provider or any health care provider with knowledge of the Member's medical condition or based on a prudent layperson's judgment which, in the absence of urgent care review time frames could:
  - Seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function or;
  - Would subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

### [Program Overview](#)

Utilization Management (UM) may be required for Pre-certification/Pre-authorization, Pre-Service (Prospective) Review, Continued Stay Review, or Post-Service (Retrospective) Review.

The determination that services are medically necessary is based on the information provided, and is not a guarantee that benefits will be paid. Payments are based on the Member's coverage at the time of service. These terms typically include certain exclusions, limitations and other conditions. Benefit payment could be limited, for example, when:

- The information submitted with the claim, or on the medical record, differs from that given by telephone, fax or electronic communication.
- The service is excluded from coverage.
- The Member is not eligible for coverage when the service is provided.

The review may consider such factors as the Medical Necessity of services provided, and whether the service involves cosmetic or experimental/investigative procedures.

UM may be conducted via multiple communication paths.

Inpatient medical admissions require UM review. UM for inpatient medical services may include but is not limited to: acute hospitalizations, units described as “sub-acute,” “step-down” and “skilled nursing facility;” designated skilled nursing beds/units; comprehensive outpatient rehabilitation facilities; rehabilitation units; inpatient hospice; and sub-acute rehabilitation facilities or transitional living centers. These services are subject to admission review for determination of Medical Necessity and appropriateness, site of service and level of care.

Non-inpatient medical services may require Pre-Service Review.

The list of **Pre-certification/Pre-authorization Requirements** can be accessed online. Go to **anthem.com**, and select **Providers**. Under the *Claims* heading, select [Prior Authorization](#). Select **Colorado** if you haven’t done so already. Select the appropriate link depending on the type of Member:

- [Prior Authorization Code Lists](#) – for Local Plan Members
- [Federal Employee Program \(FEP\) Precertification](#) – for FEP Members

Under the *Helpful Links* heading:

- [Medical Policy and Prior Authorization for Blue Plans](#) – for BlueCard Members

UM for behavioral health inpatient and non-inpatient services, including but not limited to Residential, Partial Hospitalization and intensive outpatient services, require Pre-service Review or Continued Stay Review.

### [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 UM 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 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 UM 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 UM 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.
- F. When the review is completed, the physician, hospital, facility, or other health care professional(s) and the Member receive notification of the UM determination.
- G. UM Review Timeframes follow State, Federal and accreditation requirements as may be applicable to the review.

### [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 Member's 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

Certain services may be excluded from on-site review including but not limited to Transplant.

### [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](#)

Medical records and pertinent information regarding the Member's care may be reviewed to make a Claim determination.

### [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 procedures 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 50% penalty. Providers and Facilities must present evidence of extenuating circumstances in the event that a Provider or Facility elects to dispute these reimbursement penalties.

Payment for emergency inpatient admissions will be subject to a 50% 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. Providers and Facilities must present evidence of extenuating circumstances in the event that a Provider or Facility elects to dispute these reimbursement penalties.

### 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.

### Interactive Care Reviewer (ICR)

Anthem's **Interactive Care Reviewer (ICR)** is an online tool and 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, eliminates the need to fax.
- 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.
- Update clinical information when the case is still active.

- Update the case with extension of services or discharge information.
- View, download or print all provider letters associated to the case.
- Utilize the dashboard to provide a complete view of all ICR submitted UM and behavioral health requests with real time status updates.
- Email notifications if requested using a valid email address to notify activity on the case.
- Real time decisions for some common procedures.
- Access ICR under Authorizations and Referrals via the Availity Portal.
- Request clinical Appeals.
- Check appeals status.

For additional information, visit our Interactive Care Reviewer (ICR) resources page:

Go to **anthem.com**, and select **Providers**. Under the *Claims* heading, select [Prior Authorization](#). Select **Colorado** if you haven't done so already. Under the *Interactive Care Reviewer (ICR)* heading, select [Learn More about ICR](#).

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

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

- FEP Members
- Non Anthem 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 precertification process that you use today).

### [Peer to Peer Review Process](#)

Upon the Provider's request, from an attending physician or treating provider, Anthem provides a clinical peer-to-peer conversations when an adverse medical necessity determination will be made or has been made regarding health care services for Members. The attending physician or treating provider may offer additional information and/or further discuss his/her cases with a physician or other appropriate reviewer.

In compliance with accreditation standards, a 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.

### Case Management

Case Management assists Members to optimize the use of their benefits and available community resources to gain access to quality health care in all settings.

The Case Management programs help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. The programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs. Case Management programs are confidential and voluntary and are made available at no extra cost. These programs are provided by, or on behalf of and at the request of, health plan case management staff. These Case Management programs are separate from any Covered Services. If the Member meets program criteria and agrees to take part, we will help the Member meet identified health care needs. This is reached through contact and team work with the Member and/or the Member's chosen authorized representative, treating Physician(s), and other Providers.

In addition, assistance may be provided in coordinating care with existing community-based programs and services. This may include giving information about external agencies and community-based programs and services.

### For information on which services require prior authorization under the terms of the plan

Providers can view the current list of services requiring prior authorization online in one of two ways.

*Via Availity Portal through the Interactive Care Reviewer (ICR) tool:*

Go to **Availity.com** | Log in with **User Name** and **Password** | **Patient Registration | Authorizations & Referrals** | Select either **Auth/Referral Inquiry** or **Authorizations**.

*Via anthem.com public website:*

Go to **anthem.com** | **Providers Overview** | select **Find Resources for Your State**, and pick **Colorado** | from the blue box on left side titled *Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements*, select **Enter** | select **Pre-Certification/Pre-Authorization Requirements (for Local Plan members)**.

### Minimum timeframe and information needed for filing a pre-service / prior-authorization request

Under the filing procedures of the plan, any request for a prior authorization must include the following minimum information:

- Full name, date of birth and correct Anthem health care identification (HCID) number of the patient;
- Full name(s), NPI(s) and location of any of the following provider types rendering services:
  - Surgical assists or assistant surgeons;
  - Neuromonitoring technician or neuromonitoring reading provider;
- All CPT or revenue codes for the services or supplies being requested;
- All diagnoses codes for the patient;
- The requested date, location and name of facility for the services or supplies being requested;
- Clinical information including history and physical;
- *For non-urgent prior authorization requests*, if the provider is requesting prior authorization of a surgical procedure, the request must provide the full name and NPI of any of the following providers who will be assisting or providing services during surgery:
  - Anesthesiologists
  - Surgical assistants / assistant surgeons
  - Neuromonitoring technicians or reading providers

Any request for prior authorization must be submitted to us in one of the following ways:

- Online via Availity through the Interactive Care Reviewer (ICR) tool:
  - Go to **Availity.com** | Log in with **User Name** and **Password** | **Patient Registration** | **Authorizations & Referrals** | Select either **Auth/Referral Inquiry** or **Authorizations**.
- By phone: Local Plan Members – 800-832-7850 (or reference the number on the back of the Member's ID card)

Any request for prior authorization must be submitted within the following timeframes:

**Elective/non-urgent prior authorization requests:** the initial authorization request must be submitted at least 15 calendar days prior to the requested date of service. Any concurrent outpatient review or extension of an existing outpatient authorization must be submitted at least 5 business days prior to the last authorized day under the existing authorization. For inpatient stays authorized for more than one day, any concurrent inpatient review or extension of an existing inpatient authorization must be submitted at least 24 hours prior to the last authorized day under the existing authorization.

If a request for prior authorization does not comply with these filing procedures, or is for a service or supply which does not require prior authorization under the plan, the request may be rejected. In that event, within 5 calendar days of receiving the request (or within 24 hours of receiving an urgent prior authorization request), we will notify the submitting provider and member of the failure and provide information on the proper procedures to follow. The provider can then resubmit the prior authorization request in accordance with the filing procedures.

Consistent with Colorado law, it is the participating provider's sole obligation to obtain any necessary prior authorization and the provider's failure to do so may limit the ability to bill the patient for the associated charges. Providers should ensure that they are complying with their provider contract and applicable law (including without limitation, CRS 10-16-705(3) and CRS 10-16-705(14)) before attempting to collect any amount from the patient.

---

### **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<sup>SM</sup>**

- Radiology: [www.aimprovider.com/radiology](http://www.aimprovider.com/radiology)
- Cardiology: [www.aimprovider.com/cardiology](http://www.aimprovider.com/cardiology)
- Medical Oncology : [www.cancercarequalityprogram.com](http://www.cancercarequalityprogram.com)
- Radiation Oncology: [www.aimprovider.com/radoncology](http://www.aimprovider.com/radoncology)
- Genetic Testing: [www.aimprovider.com/genetictesting](http://www.aimprovider.com/genetictesting)
- Sleep: [www.aimspecialtyhealth.com/gowebssleep](http://www.aimspecialtyhealth.com/gowebssleep)
- Specialty Drugs: [www.aimprovider.com/specialtyrx](http://www.aimprovider.com/specialtyrx)
- Musculoskeletal: [www.aimprovider.com/msk](http://www.aimprovider.com/msk)
- Surgical Procedures: [www.aimproviders.com/surgicalprocedures](http://www.aimproviders.com/surgicalprocedures)
- Rehabilitation: [www.aimproviders.com/rehabilitation](http://www.aimproviders.com/rehabilitation)

### 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**<sup>SM</sup> directly at [providerportal.com](https://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](https://availity.com)
- Call the AIM Contact Center toll-free number: 877-291-0366

### 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](https://providerportal.com).
  - *You may also access AIM via the Availity Portal at [availity.com](https://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
- Doctors of dentistry providing Health Services covered under the Health Benefit Plan including 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 provide treatment services under the Health Benefit Plan
- Telemedicine practitioners 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 Dieticians



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 settings, 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](#)

MemberAnthem 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](http://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**

<b>Verification Element</b>
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 <ol style="list-style-type: none"><li>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.</li></ol>
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

<b>Verification Element</b>
State Medicaid Exclusion Listing, if applicable

## **B. HDOs**

<b>Verification Element</b>
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 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 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 participation poses an imminent risk of harm to Members. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for Informal Review/Reconsideration or Formal Appeal. Participating practitioners and HDOs 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.
  - 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.
- B. 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:
  - (f) controlled substances from these Schedules are not prescribed within his/her scope of practice; and
  - (g) 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
  - (h) DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than those aforementioned.
- 10. MemberNo 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. 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.
- 13. No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence.
- 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. 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.

C. 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](http://www.nursecredentialing.org)), a subsidiary of the American Nursing Association ([http://www.nursingcertification.org/exam\\_programs.htm](http://www.nursingcertification.org/exam_programs.htm)); or
  - ii. American Academy of Nurse Practitioners – Certification Program ([www.aanpcertification.org](http://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 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.

#### D. Currently Participating Applicants (Recredentialing)

- 2. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
- 3. Re-credentialing application signed date within one hundred eighty (180) calendar days of the date of submission to the CC for a vote;
- 4. 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).
- 5. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to Members;
- 6. No new history of licensing board reprimand since prior credentialing review;
- 7. \*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);
- 8. Current DEA/CDS registration and/or state controlled substance certification without new (since prior credentialing review) history of or current restrictions;
- 9. 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;
- 10. No new (since previous credentialing review) history of or current use of illegal drugs or alcoholism;
- 11. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
- 12. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;

13. 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.
14. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
15. 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.
16. No QI data or other performance data including complaints above the set threshold.
17. 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 recredentialing.

### **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 recredentialed at least every three (3) years to assess the HDO's continued compliance with Anthem standards.

**A. General Criteria for HDOs:**

1. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to 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 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**

<b>Facility Type (Medical Care)</b>	<b>Acceptable Accrediting Agencies</b>
Acute Care Hospital	CIQH, CTEAM, DNV/NIAHO, HFAP, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC
Birthing Center	AAAHC, CABC, TJC
Clinical Laboratories	CLIA, COLA
Dialysis Center	CMS Certification, TJC
Home Health Care Agencies (HHA)	ACHC, CHAP, CTEAM, DNV/NIAHO, TJC
Home Infusion Therapy (HIT)	ACHC, CHAP, CTEAM, HQAA, TJC
Portable Xray Services	FDA Certification
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, HFAP, TJC
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAHC, 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

### [Become a contracted Provider or Facility](#)

To learn more about becoming a contracted Provider or Facility, view the steps in the provider application process and the forms you'll need to apply online. Go to **anthem.com**. Select **Providers**, and **Provides Overview**. Select **Find Resources for Your State**, and pick **Your State**. From the **Provider Home** page, select the tab titled [Join Our Networks](#).

*(Note: Before completing an application, please see the [Join Our Networks](#) page for further details on Credentialed Providers, Non-credentialed Providers, and Ancillary closed networks.)*

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

Provider	Standards of Participation
Ambulance (Air & Ground)	Medicare Certification
Ambulatory Infusion Suites	JCAHO, CHAP or ACHC State & Pharmacy Licensure
Durable Medical Equipment	JCAHO, CHAP, ACHC Medicare Certification Medicinal Gas License
Hearing Aid Supplier	State Licensure
Orthotics & Prosthetics	JCAHO, CHAP, ABC or BOC (Ocularist: NEBU Preferred) Medicare Certification

*\*Please note: This is only a representative listing of provider types that do not require formal credentialing. If you have questions about whether you are subject to the formal credentialing process or the applicable standards of participation for your provider type, please contact your provider contracting representative.*

---

## Quality 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 are expected to cooperate with Quality Improvement activities. Our commitment to health improvement and care management provides added value to Members and health care professionals – helping improve both health and health care costs. Anthem takes a leadership role to improve the health of 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, objectives, structure, and responsibilities encompassing the quality of medical and behavioral health care and services provided to Members.
- The 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 for Members and improving medical and behavioral health care: quality of clinical care, safety of clinical care, quality of service, and Members' experience.
- The QI Evaluation assesses outcomes of Anthem's medical and behavioral health care programs, processes, activities, and performance in the quality and safety of clinical care and services. The QI Evaluation also evaluates how the QI Program goals and objectives were met.

## **Goals and Objectives**

The following QI Program goals and objectives support Anthem's vision and values, promote continuous improvement in quality care, patient safety for Members, and quality of service to 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, policies and procedures.
- To promote processes that help reduce medical errors and improves patient safety for Members by implementing member-focused, provider and safety initiatives.
- To identify and promote the educational opportunities for Members, medical and behavioral health 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 ("CM") and Disease Management ("DM") 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 Chronic Obstructive Pulmonary Disease (“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, 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 has committed resources and worked with key entities to co-create community-based health initiatives to address public health concerns and societal problems including behavioral health/substance abuse disorder, cancer, diabetes, and maternal and child health.
- *Disease Management:* The ConditionCare program is designed to help maximize health status, improve health outcomes, and 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 COPD. The DM program was created and developed based on recent versions of nationally accepted evidence-based Clinical Practice Guidelines (“CPGs”). These guidelines are reviewed at least every two years, and program interventions and protocols are updated accordingly.
- *Health and Wellness:* Programs offer a seamless integration of preventive care, wellness, care management coordination services, and on-line and mobile tools. The programs are clinically driven and designed to help Members better manage individual health and make more informed health care decisions. Programs include: MyHealth Coach (“MHC”), MyHealth Advantage (“MHA”), Neonatal Intensive Care Unit (“NICU”) program, Worksite Wellness, Healthy Lifestyles (“HL”), and Healthwise® Knowledge Base (“HWKB”).

### Service Quality

Anthem periodically surveys its Members, monitors the quality of care and service of network providers and strives to provide excellent service to Members, Providers and Facilities. Anthem actively analyzes business processes, trends, identifies and takes action on opportunities to improve the Member, Provider and Facility experience, recommending appropriate activities to address root causes.

## Patient Safety for Members

The strategic vision is to establish and maintain goals in advancing patient safety for Members. This program is structured to align with the overall mission and national patient safety strategy for Members. The goals are to work with physicians, hospitals in the network, 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, protection, engagement, care management, and payment innovation. Patient safety for member initiatives are managed by various business units within the enterprise, but tracked by a single unit. 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.

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

## 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 online. Go to **anthem.com**. Select **Providers**, and **Provides Overview**. Select **Find Resources for Your State**, and pick **Your State**. Select the **Health & Wellness** tab, then **Quality Improvement and Standards**, and finally [Member Rights and Responsibilities](#). Members or Providers who do not have access to the website can request copies by contacting Anthem. If Members and Providers need more information or would like to contact us, they are instructed to go to **anthem.com**. Select **Providers**, and under the *Communications* heading select **Contact Us**. Or Members can call the Member Services number and Providers can call the Provider Services number on the back of the Member ID card."

## 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, enhancing 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.

## Health Promotion and Wellness

### **Online Health Information**

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

### **Collaboration with the Colorado Immunization Information System**

In January 2004, Anthem began participating in the Colorado Immunization Information System ("CIIS"), which is a computerized information system operated by the University of Colorado Health Sciences Center on behalf of the Colorado Department of Public Health and Environment ("CDPHE") under the Colorado Immunization Act. CIIS helps Colorado health care providers collect vaccination histories to help ensure correct and timely immunizations for children. Anthem is participating by sending claims information about immunizations to CIIS, where that information is uploaded and integrated into each child's record.

The CIIS helps physicians in providing quality patient care by displaying recommended immunizations at each visit based on current Advisory Committee on Immunization Practices ("ACIP") standards, highlighting reactions and contraindications, producing labels for mailing immunization reminders to patients, and immediately identifying patients for vaccine recalls.

The database is web-enabled and, with no fee, may be accessed using Internet Explorer 5.5 or higher. Providers must sign a user agreement with CIIS and obtain an ID and password. Participating immunization providers may input and retrieve patient immunization data twenty-four (24) hours a day, seven (7) days a week, including retrieving immunization information about new patients entered by other offices. Providers also may print immunization forms for school, day care and camp without pulling charts, and track vaccine usage. Immunizations for a child are kept in a single record, even if the child is seen by more than one provider. CIIS allows a provider to review a patient's immunization history at each visit and quickly determine what immunizations are due, based on ACIP recommendations. CIIS participation is voluntary for providers and parents, and parents may have their child's immunization data excluded. CIIS provides the forms a provider needs to inform a parent of the right to exclude the information and of the benefits of having the child's immunization information in the system.

The Immunization Act allows CIIS to gather immunization information from the child's immunization provider, clinics, schools, the child's parent, the child, the managed care organization or health insurer with which the child is enrolled, and hospitals or entities contracted with the CDPHE under the Immunization Act. Information in the CIIS may

only be released to those entities that provide information, plus the Colorado Department of Health Care Policy and Financing for children enrolled in Medicaid. Under the Immunization Act, any person releasing information from the CIIS to another individual not permitted to have such information is committing a crime and may be punished.

HIPAA regulations state that a covered entity may release immunization information without prior authorization to an immunization information system authorized by a state law such as the Immunization Act. The covered entity must keep track of all releases of protected health information. CIIS keeps a complete record of all information needed to comply with the HIPAA tracking requirements and will furnish a report to a participating immunization provider at no cost.

For more information, please call the CIIS at 303-724-1074 or 888-611-9918.

### [Conflict of Interest](#)

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

---

## 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**, and **Provides Overview**. Select **Find Resources for Your State**, and pick **Your State**. Select the **Health & Wellness** tab at the top of the page. Select **[Quality](#)**



**Improvement and Standards** from the drop down list, and 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 our provider 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. Our Provider newsletters can be found online at [anthem.com/provider/news](https://www.anthem.com/provider/news)

*® 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 online. To access the guidelines, go to **anthem.com**. Select **Providers**, and **Provides Overview**. Select **Find Resources for Your State**, and pick **Your State**. From the Provider Home page, under the **Health and Wellness** tab, select **Practice Guidelines**, then [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 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 online. To access the guidelines, go to **anthem.com**. Select **Providers**, and **Provides Overview**. Select **Find Resources for Your State**, and pick **Your State**. From the Provider Home page, under the **Health and Wellness** tab, select **Practice Guidelines**, then [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 visit our website. Go to **anthem.com**. Select **Providers**, and **Provides Overview**. Select **Find Resources for Your State**, and pick **Your State**. From the **Health and Wellness** tab, select [Quality Improvement and Standards](#), and then scroll down to “**Medical Record Review**”.

---

## Multicultural Health

### [Multicultural Health Overview](#)

Anthem identifies and addresses health and healthcare disparities among Members based on key clinical quality metrics, evidence-based research, and member experience metrics. We aim to help eliminate these disparities and promote health equity. Our core strategies for helping to mitigate disparities and achieve equity include the following:

1. Monitor the quality of health care to identify actionable health and health care disparities trends
  - a. Identify clinical and geographic areas exhibiting health and health care disparities and design appropriate interventions to help close those gaps
  - b. Establish baseline data and measures/evaluates the results of program interventions
  - c. Support Member access to equitable treatment, standards of care and services based on their Plan benefits
2. Promote Culturally and Linguistically Appropriate Services (“CLAS”)
  - a. Offer 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. Facilitate cultural competency of Anthem associates to help meet the Members’ needs for access to 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
  - d. 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>

3. Develop programs to help improve health status and outcomes
  - a. Promote consumer-centered care that addresses the Members' values, needs and preferences in reaching optimal health care and outcomes standards
  - b. Support communities in which Anthem does business with cultural and linguistic programs and services
  - c. Collaborate with other industry and government efforts to help reduce and eliminate health disparities

### [Anthem Innovation](#)

### **[MyDiversePatients.com](#): An online resource to support your diverse patient panel**

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

All learning experiences can be found on [MyDiversePatients.com](#), a website that 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.

While there's no single easy answer to the issue of health care disparities, the vision of [MyDiversePatients.com](#) is to start reversing these trends...one patient at a time.

Embrace the knowledge, skills, ideals, strategies, and techniques to accelerate your journey to becoming your patients' trusted health care partner by visiting [MyDiversePatients.com](#) today. Descriptions of the learning experiences and tools are listed below.

### **Moving Toward Equity in Asthma Care**

Built upon extensive research and data analytics, the "Moving Toward Equity in Asthma Care" online CME xperience 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 and can be accessed at [www.mydiversepatients.com/le-asthma.html](http://www.mydiversepatients.com/le-asthma.html).

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

## **Asthma & Me App**

Are you looking for innovative ways to educate and engage your patients with asthma? The Asthma & Me app is an interactive and fun way to show patients the physiology of their asthma. The app is a free support tool that 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 [MyDiversePatients.com](http://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.mydiversepatients.com/le-asthma.html](http://www.mydiversepatients.com/le-asthma.html)

## **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 promotes 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 [www.mydiversepatients.com/le-lgbt.html](http://www.mydiversepatients.com/le-lgbt.html) for free 24/7 access to the experience – either via your computer, tablet or smartphone. The course has been approved for 1 AAFP Prescribed credit, which is equivalent to AMA PRA Category 1 Credit™.

## **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 about 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.mydiversepatients.com/le-hcst.html](http://www.mydiversepatients.com/le-hcst.html) 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™.

## Medication Adherence

You want what's best for your patients' health. So, it's challenging when a patient doesn't follow your prescribed treatment plan. Why do approximately 50% of patients with chronic illness stop taking their medications within one year of being prescribed<sup>1</sup>? Where's the disconnect? What can be done differently?

As a health care provider, you care about your patients. However, you may only be seeing and hearing the tip of the iceberg—the observable portion of the thoughts and emotions your patient is experiencing. The barriers that exist under the waterline -- the Titanic-sized, often invisible, patient self-talk that may not get discussed -- can create a misalignment between patient and provider.

So we've created an online learning experience for the skills and techniques that may help you navigate these uncharted patient waters. After completing the learning experience you'll know how to see the barriers, use each appointment as an opportunity to build trust, and bring to light the concerns that may be occurring beneath the surface of your patient interactions. Understanding and addressing these concerns may help improve medication adherence—and you'll earn CME credit along the way. The course is approved for 1 AAFP Prescribed credit, which is the equivalent to AMA PRA Category 1 Credit™.

Take the next step. Go to [MyDiversePatients.com](https://mydiversepatients.com) > ***The Medication Adherence Iceberg: How to navigate what you can't see*** to enhance your skills.

<sup>1</sup> 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>

---

## 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 Blue and Shield Association (“BCBSA”) and other Blue plans to ensure adequate geographic coverage. The BCBSA refers to its designated CME providers as Blue Distinction Centers for Specialty Care™ (“BDC”). Using objective information and input from the medical community, the BCBSA have designated hospitals as Blue Distinction Centers that are proven to outperform their peers in the areas that matter to you – quality, safety and, in the case of Blue Distinction Centers+ (“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 online at [anthem.com](https://www.anthem.com). Select **Providers**, and **Provides Overview**. Select **Find Resources for Your State**, and pick **Your State**. Select the **Health & Wellness** tab at the top of the page, and click [Centers of Medical Excellence](#).

## Transplant

- Blue Distinction Centers for Transplant™ (“BDCT”) launched in 2006.
- More than 115,082 people in the United States were waiting for a life saving organ transplant from one of the nation’s more than 140 transplant centers 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 200 transplant specific programs for heart, lung, combined heart/lung, liver, pancreas, kidney, combined kidney/pancreas, and bone marrow/stem cell transplant.

## **Cardiac Care**

- Blue Distinction Centers for Cardiac Care® launched in January 2006.
- According to the Centers for Disease Control and Prevention, 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.

### **Chimeric Antigen Receptor Therapy (“CAR-T”)**

- The FDA has approved a new product Chimeric Antigen Receptor T-cell (CAR-T), a CD19-directed genetically modified autologous T cell immunotherapy which brings new treatment options for cancer patients.
- Two (2) Chimeric Antigen Receptor T cell therapies (CAR-T) have been recently approved by the FDA to treat certain patients with leukemia and lymphoma:
  1. Yescarta for treatment in Adult Patients
  2. Kymriah for treatment in Pediatric and Adult Patients
- These procedures can be performed in the Inpatient (IP) or Outpatient (OP) setting and Care and follow-up continues over the first year.
- These Members are managed by the transplant Case Managers and Anthem Medical Policy requires the procedure be performed at a Certified CAR-T center.
- Currently there is not a designation or contract for CAR-T therapy and each case requires a Letter of Agreement. In 2019 Anthem Centers of Medical Excellence will have a designation and contract for CAR-T
- The Blue Cross Blue Shield Association will also have a designation, but not a contract requirement for CAR-T Providers in 2019.

---

## Product/Network Summary

### [Networks Overview](#)

Please reference our Networks Overview document on anthem.com for the different networks offered. The document includes specifics about each network, how to identify members aligned with each network, and sample ID cards.

Go to **anthem.com**, and select **Providers**. Under the *Provider Resources* heading, select **Forms and Guides**. Search for [Networks Overview](#). Select **Colorado** if you haven't done so already.

### [Networks at a Glance](#)

Please reference our Networks at a Glance document on anthem.com for a snapshot of the different networks offered. The document includes Network Names, Product Type, Agreement needed for participation, Three-character Prefix, PCP required, and if PCP referral is required for each network.

Go to **anthem.com**, and select **Providers**. Under the *Provider Resources* heading, select **Forms and Guides**. Search for [Networks at a Glance](#). Select **Colorado** if you haven't done so already.

### [BlueCard Program](#)

Please refer to the separate section titled **BlueCard Program Overview** for additional information.

### [Federal Employees Health Benefits Program](#)

Please refer to the separate section titled **Federal Employees Health Benefits Program** for additional information.

### [HMO Colorado Point-of-Service Rider](#)

HMO Colorado offers employer groups a point-of-service ("POS") rider designed to complement BlueAdvantage HMO benefits. The POS rider is an "opt-out" product for members who want to receive covered health care services without guidance from a PCP in the HMO Colorado network.

***In-network (HMO benefits):*** A member must select a PCP. If the member follows HMO Colorado guidelines and sees only the selected PCP or seeks services from in-network specialists, the member receives the member's BlueAdvantage HMO benefits, less any

in-network copayments. Emergency benefits are provided through HMO Colorado if the member follows HMO Colorado procedures.

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

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

- Ambulance services (except emergency ambulance services)
- Infertility services
- Behavioral health care services, except biologically based mental health services, i.e., for parity diagnoses (see the Behavioral Health and Chemical Dependency Rehabilitation Services section of this Manual for a listing of parity diagnosis codes) or autism, posttraumatic stress disorder, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, general anxiety disorder, anorexia nervosa and bulimia nervosa
- Thirteen (13) Certain organ transplants

#### [HMO Colorado Away from Home Care® Program](#)

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

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

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

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

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

### **BlueCard Member Eligibility**

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

If you can't locate a three-character prefix on the member's ID card, check for a phone number on the back of the ID card. If that's not available, call the provider customer service phone number in the [Prefix Reference List](#) in the Telephone and Address Directory section of the Manual.

---

## Medicare Advantage

### [Medicare Advantage Provider Website](#)

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

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

- [Medicare Advantage Provider Guidebook](#)

---

## Federal Employees Health Benefits Program

### [FEBHP 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 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 three hundred and sixty five (365) 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 three hundred and sixty five (365) 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 three hundred and sixty five (365) 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 under the FEHBP](#)

For erroneous or duplicate Claim payments under the FEHBP, either party shall refund or adjust, as applicable, all such duplicate or erroneous Claim payments regardless of the cause. Such refund or adjustment may be made 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 Blue Cross and Blue Shield Service Benefit Plan 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 calendar 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 FEP).

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).

---

## 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 posted online. Go to **anthem.com**. Select **Providers**, and **Provides Overview**. Select **Find Resources for Your State**, and pick **Colorado**. From the **Communications tab**, under the *Provider Manuals* heading, select the link titled [BlueCard Provider Manual](#).

---

## Health Insurance Marketplace (exchanges)

### [Health Insurance Marketplace](#)

The Affordable Care Act (ACA) authorized the creation of Health Insurance Marketplaces (commonly referred to as exchanges) to help individuals and small employers shop for, select, and enroll in high quality, affordable private health plans.

Anthem offers qualified health plans on the Individual or Small Business Health Options Program (SHOP) Exchange in many states, as well as health plans not purchased on public exchanges. Qualified health plans on the Individual and SHOP Exchange follow the same policies and protocols within this Provider Manual, unless otherwise stated in your Agreement.

Updates about Anthem's ACA compliant health plans and the networks supporting these plans are published in Anthem's provider newsletter, and sent via Anthem's email service. To sign up for Provider Communications for Colorado, 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](http://anthem.com).

### **Important reminder:**

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.

### [Affordable Care Act \(ACA\) – Quick Reference Guide](#)

- [Affordable Care Act \(ACA\) – Quick Reference Guide \(Colorado\)](#)

---

## 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 Provider or Facility 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 Provider or Facility 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 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, Providers and 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 Member 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 prepayment 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 outline 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 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 documentation 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.
- *Edits:* 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.

### Prepayment Review

One method Anthem uses to detect FWA is through pre-ayment Claim review. Through a variety of means, certain Providers or Facilities, or certain Claims submitted by Provider or Facilities, may come to Anthem’s attention for behavior that might be identified as unusual for coding, documentation and/or billing issues, 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 or has otherwise come to Anthem’s attention for reasons mentioned above, further investigation is conducted by the SIU to determine the reason(s) for the outlier status or any approximate explanation for unusual coding, documentation, and/or billing practice. 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 prepayment review. If that occurs, the Provider or Facility will receive written notice of being placed on prepayment review. This means that the Provider or Facility will be required to submit medical records and any other supporting documentation with each Claim so Anthem can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation 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 prepayment review status.

Under the prepayment review program, Anthem may review coding, documentation, 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's Members.

The Provider or Facility will remain subject to the prepayment review process until Anthem is satisfied that all inappropriate billing, coding, or documentation 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 Member for services we have determined are not payable as a result of the prepayment review process, whether due to FWA, any other coding or billing issue or for failure to submit medical records as set forth above. Providers and 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.

#### [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.

#### [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 ("Overpayment Amount") against any payments due and payable by Anthem or any Affiliate to Provider or Facility with respect to any Health Benefit Plan under this Agreement or under any provider agreement between Provider and an Affiliate regardless of the cause. Provider or

Facility shall voluntarily refund the Overpayment Amount 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 an Overpayment Amount is due from Provider or Facility, Provider or Facility must refund the Overpayment Amount to Anthem within thirty (30) calendar days of the date of the overpayment refund notice from Anthem to the Provider or Facility. If the Overpayment Amount is not received by Anthem within the thirty (30) calendar days following the date of such notice letter, Anthem shall be entitled to offset the unpaid portion of the Overpayment Amount against other Claims payments due and payable by Anthem or an Affiliate 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, including Affiliate Claim payments, applied to satisfy Provider's or Facility's repayment obligation shall be deemed to have been legally paid to Provider or Facility in full for all purposes, including Affiliates and/or Regulatory Requirements as defined by the Provider or Facility Agreement. Should Provider or Facility disagree with any determination by Anthem or a Plan that Provider or Facility has received an overpayment or improper payment, Provider or Facility shall have the right to appeal such determination under Anthem's procedures set forth in the Provider Manual, provided that such appeal shall not suspend Anthem's right to recoup the Overpayment Amount during the appeal process unless required by Regulatory Requirements. 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 the 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. Following the selection of the Member's new

Pharmacy Home, all prescribing physicians receive notification of the Member's enrollment into the program, the assigned pharmacy information and a 3-month prescription profile containing a list of all prescribers, medications, dosages, and quantities received by the Member during that timeframe.

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 Claims<sup>1</sup> are denied if filled at any pharmacy other than the Member's assigned Pharmacy Home<sup>2</sup>.
- 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 if<sup>3</sup>:

- 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 Member 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 on the 31st day based off of their pharmacy Claims. Anthem will ensure both the Member and their Provider will be notified of their new Pharmacy Home in writing. Once they have chosen a Pharmacy Home, 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.



<sup>1</sup> Both controlled and non-controlled medications must be filled at the designated Pharmacy Home.

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

<sup>3</sup> 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.)

## Laboratory Services

### Laboratory Procedures

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

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

### Lab Work that can be provided in the Provider’s Office

HCPCS	Description
80048	<i>Metabolic panel total</i>
81000	<i>Urinalysis, nonauto w/scope</i>
81001	<i>Urinalysis, auto w/scope</i>
81002	<i>Urinalysis nonauto w/o scope</i>
81003	<i>Urinalysis, auto, w/o scope</i>
81005	<i>Urinalysis</i>
81007	<i>Urine screen for bacteria</i>
81015	<i>Microscopic exam of urine</i>
81025	<i>Urine pregnancy test</i>
82120	<i>Amines, vaginal fluid, qualitative</i>
82270	<i>Occult blood, feces</i>
82271	<i>Occult blood, other sources</i>
82803	<i>Gases, blood, any combination of pH, pCO<sub>2</sub>, pO<sub>2</sub>, CO<sub>2</sub>, HC0<sub>3</sub> (including calculated O<sub>2</sub> saturation). This procedure approved for Pulmonologists ONLY.</i>
82947	<i>Glucose; quantitative (except reagent strip)</i>



<b>HCPCS</b>	<b>Description</b>
82948	<i>Glucose; blood reagent strip</i>
82962	<i>Glucose; blood by glucose monitoring device(s) cleared by the FDA specifically for home use.</i>
83986	pH; body fluid. Not otherwise specified.
85002	<i>Bleeding time</i>
85007	<i>Blood count; blood smear, microscopic examination with manual differential WBC count</i>
85013	Spun microhematocrit
85014	Hematocrit
85018	Hemoglobin
85025	Complete CBC w/auto diff WBC
85610	Prothrombin time
86308	Heterophile antibodies (momo spot)
86403	Particle agglutination test (Rapid Strep)
86580	TB intradermal test
87081	Culture screen only (Rapid Strep)
87205	Smear, gram stain
87210	Smear, wet mount, saline/ink
87220	Tissue exam for fungi
87430	Strep a ag, eia (Rapid Strep)
87802	Infectious agent antigen detection by immunoassay with direct optical observation; Streptococcus, group B
87804	Influenza assay w/optic
87807	Rsv assay w/optic
87880	Strep a assay w/optic
88172	Cytopathology – evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site.
88173	Interpretation and report
88177	Immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site (list separately in addition to code for primary procedure).

HCPCS	Description
89300	Semen analysis w/huhner
89310	Semen analysis w/count
89320	Semen analysis, complete
89321	Semen analysis & motility
89330	<i>Sperm evaluation; cervical mucus penetration test, with or without spinnbarkeit test</i>
G0027	<i>Semen analysis</i>

Lab procedure codes for procedures that can be performed at the physician's office can be billed as fee-for-service. Codes on this list are not a guarantee of payment. Coverage may be restricted by member benefits.

Venipuncture and blood collection services:

- Effective January 1, 2010, codes 36415 and S9529 venipuncture, and/or 36416, collection of capillary blood specimen (e.g. finger, heel, or ear stick) are allowed in addition to the lab and/or the E/M code. (Only one of these codes should be reported per visit).
- Anthem follows 2014 CPT parenthetical coding guidelines which state that CPT codes 36591 – Collection of blood specimen from a completely implantable venous access device and 36592 – Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified, should not be reported "...in conjunction with other services except a laboratory service<sup>1</sup>". Therefore, these codes are only eligible for separate reimbursement when billed with a laboratory service.
- Please refer to Reimbursement Policy: *Laboratory and Venipuncture Services* for implementation dates for ClaimsXten editing for these services.

<sup>1</sup>current procedural terminology *cpt*® 2013 Professional Edition, pg. 215

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

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

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

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

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

- Routine pediatric specimen collections can be performed at the drawing stations of the independent laboratories contracted with Anthem.
- **STAT:** If an emergency situation exists and you can't wait for LabCorp's stat turnaround (three to four hours from the time the lab is called), you can mark "STAT" on your claim form for that lab procedure. However, Anthem will pay the lab charge only and will not pay for "STAT" fee charges.
- If the original claim doesn't denote "STAT" and is denied for payment because it should have been sent to LabCorp, Anthem will not pay at a later date even if the claim is resubmitted with "STAT" marked on it.
- **Cerebrospinal fluid/bone marrow aspirate:** Due to the labile nature of these specimens, Anthem recommends that they be transported to the nearest hospital for analysis. Please call LabCorp for information or instructions. This also helps with reporting results properly and obtaining written copies of the results.
- **Non-gynecologic cytology:** Place specimens such as urine, bladder washing, body fluids (peritoneal, gastric), cyst fluids and cerebrospinal fluids in a clean, leak-proof container with an equal volume of fifty percent (50%) alcohol.
- **Histology:** Place tissue in leak-proof biopsy bottles containing ten percent (10%) formalin in a volume five (5) times that of the specimen. Do not use a preservative if microbiological cultures are required.

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

### Other Considerations

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

Q0091-Obtaining the specimen for cervical cancer screening is included in the allowance for and is thus incidental to the E/M or the preventive care visit service and is not reimbursed separately. Please refer to Reimbursement Policies: Bundled Services and Supplies, Modifier 59 and Screening Services with Evaluation and Management Services.

### Specialized Anatomic Pathology

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

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

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

### LabCorp Patient Service Centers

To find a LabCorp location near you, go to [www.LabCorp.com](http://www.LabCorp.com) or call one of the phone numbers above.

---

## Pharmacy Services

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

### Prescription Drug Benefit Design

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

Drug Category	Member Copayment
Generic X on formulary (tier 1 or 1a/1b)	<b>Tier-1 or 1a/1b</b> - means a drug that has the lowest Copayment. This tier has low cost or preferred medications. This tier mainly includes Generic Drugs, some Single Source Drugs and some Multi-Source Drugs. Older generics are typically Tier 1 or 1a. For

Drug Category	Member Copayment
	those benefits with split tier generics, tier 1b is a higher copayment.
Brand A formulary – no generic equivalent available (tier 2)	<b>Tier-2</b> - means a drug that has a higher Copayment than those in tier 1. This tier has preferred medications that generally are moderate in cost. This tier may include Generic Drugs, Single Source Drugs and Multi-Source Drugs.
Brand C non-formulary – no generic equivalent available (tier 3)	<b>Tier-3</b> - means a drug that has a higher Copayment than those on tier 2. This tier may have non-preferred medications which are generally higher in cost. This tier may include some Generic Drugs, Single Source Drugs, and Multi-Source Drugs.
<b>Tier 4/5</b>	<b>Tier-4</b> - means drugs with the highest Copayment. This tier has medications which are generally highest in cost. These are typically specialty medications and may include Generic Drugs, Single Source Drugs, and Multi-Source Drugs. For those benefits with a split specialty tier, preferred products are tier 4, non-preferred are tier 5 and have a higher member cost share.
Benefit exclusion examples: Some drugs, such as some over-the-counter agents, sexual dysfunction agents, those used for cosmetic purposes, etc. or Prescription Drugs that have a Clinically Equivalent alternative, even if written as a prescription.	Full cost of drug

Additional formulary/drug list information is available online. Anthem has multiple formulary/drug lists; please select the appropriate drug list when searching for covered medications. Please go to the following link on the Anthem provider Portal: <http://www.anthem.com/health-insurance/customer-care/forms-library>. **You can also download information and updates to a handheld Palm Pilot at [www.ePocrates.com](http://www.ePocrates.com).**

## Specialty Medications

Specialty medications must be obtained through Anthem's contracted **Specialty Pharmacy** (Accredo or a limited distribution pharmacy provider). The list of specialty medications can be located online at anthem.com. Please go to the following link on the Anthem provider Portal, under forms:

<https://www.anthem.com/pharmacyinformation/home.html>.

The list of specialty medications is subject to change.

## **Pharmacy Benefit Drugs Requiring Authorization**

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

- **Prior authorization** may require a member to obtain approval before receiving benefits to cover the medication.
- **Step therapy** may require a member to use another medication first before receiving benefits for the requested medication.
- **Quantity limits** may affect the quantity of a certain medication for which a member can receive benefits each month.
- **Dose optimization** (or dose consolidation) usually involves converting from a twice-daily dosing schedule to a once-daily dosing schedule. A once-daily dosing schedule may increase compliance and decrease expenses for the member and Anthem.

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

A complete list of medications and prior authorization forms can be found at the following link via the Anthem.com provider website:  
<https://www.anthem.com/pharmacyinformation/home.html>.

## Clinically Equivalent Medications Program

**Our insured business and a number of our other health plan clients no longer cover certain medications.** As some therapeutic drug classes include drugs that are equally effective, we have begun excluding coverage for certain prescription drugs within a therapeutic class that don't provide the best value while continuing to cover less costly, clinically equivalent alternatives including some over-the-counter products. For a

complete list of medications under this program, please go to the following link, <https://www.anthem.com/pharmacyinformation/home.html>.

### GenericSelect Program

**GenericSelect** allows current Anthem members to receive their first prescription of a select generic drug for no co-payment. The customer may have **one (1)** co-payment waived at mail and/or retail. This is a voluntary program. A list of current medications in the program can be obtained by calling the customer service department on the back of the member's health plan ID card. The retail portion of this program is available to **all** customers who are first time users of the selected generic medication (This does not apply to CDH products, like HSA). Customers can receive **one (1) thirty (30) day supply** of the same select generic medications at the retail pharmacy with the first co-payment waived. The mail program allows customers currently receiving a targeted brand medication to receive **one (1) ninety (90) day supply** of the select generic through the mail for no co-payment. Additional fills will be charged any applicable copayment.

### Half-Tab Program

Anthem **Half Tablet** program is designed to help members save up to fifty percent (50%) on out-of-pocket costs for select medications by splitting tablets in half. Members who participate in this voluntary program can expect to save immediately by either reducing their copayment or reducing their portion of coinsurance paid. This is a voluntary program and tablet splitters are provided. A list of current medications in the program can be obtained by calling the customer service department on the back of the member's health plan ID card.

### Home Delivery Pharmacy Program

Anthem members can enroll in and use the Home Delivery Pharmacy program for up to a ninety (90) day supply of maintenance medications, which are those medications used to treat chronic health conditions. With many Anthem prescription drug plans, our members usually have reduced copayments and can therefore save money by using home delivery pharmacy.

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

### Specialty Pharmacy Services

Anthem's contracted **Specialty Pharmacy** (Accredo or a limited distribution pharmacy provider), is Anthem's preferred source for specialty prescription medications. For more information about specialty medications, please call 877-500-3701 toll free, or go online to view the current specialty drug list. Please go to the following link on the Anthem

website, under the forms library:

<https://www.anthem.com/pharmacyinformation/home.html>.

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

Anthem's Specialty Pharmacy offers you and our members these personalized services and resources:

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

To use Anthem's contracted Specialty Pharmacy to fill specialty medications for your Anthem patients (self-administered medications), you have two options:

1. **Call toll free at 877-500-3701.** A care coordinator will get the information that's needed to begin the prescription process. Care coordinators are available **from 6 a.m.-7 p.m. Mountain Time, Monday through Friday.** For TDD/TTY assistance, our members can call 800-221-6915 toll free from 6:30 a.m.-3 p.m. Mountain Time, Monday through Friday.
2. **Fax the prescription and a copy of the member's health plan ID card to Anthem's Specialty Pharmacy toll free at 800-824-2642.**

### [Pharmacy Benefit Management and Drug List/Formulary](#)

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

**Clinical Review Committee ("CRC"):** The CRC assigns clinical designations to medications. The designations are determined through review of the medical literature including but not limited to, clinical trial data, current guidelines, and treatment criteria from sources like major medical publications, professional journals, medical specialists, product package inserts, etc.



**Value Assessment Committee (“VAC”):** The VAC meets after the CRC has established the clinical foundation and rationale. Its role is to determine tier assignments, or coverage levels, for medications. To help ensure clinical guidelines are properly balanced with financial considerations, the VAC must take into account the CRC’s clinical designations when recommending medications for the Anthem national drug list/formulary. In addition to the designations assigned by the CRC, the VAC may also look at financial information (e.g., average wholesale price, rebates, ingredient cost, cost of care, copayments and coinsurance), market factors, and the impact on members to determine tiers/levels. The VAC is responsible for creating tier assignments that appropriately balance the impact on clinical, financial and member considerations.

Additions to the Anthem drug list/formulary currently occur four (4) times a year. Formulary deletions can occur at least twice a year. For Anthem members to receive their highest level of benefits, all Providers and Facilities should use the drug list/formulary when prescribing medications. A copy of the drug list/formulary is available online. Go to the following link,

<https://www.anthem.com/pharmacyinformation/home.html>. You can also download information and updates to a handheld Palm Pilot at [www.ePocrates.com](http://www.ePocrates.com).

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

---

## **Behavioral Health and Chemical Dependency Rehabilitation Services**

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

- All Local Plan members: 800-424-4014
  - Local Plan members are defined by referencing the [Prefix Reference List](#).
- FEP members: 800-424-4011
  - *FEP members are identified by the following prefix:*  
R + 8 numerics

**Please note:** Anthem’s behavioral health operations doesn’t manage behavioral health and chemical dependency rehabilitation services for BlueCard and national account

members. For those members, please refer to the behavioral health/substance abuse phone number on the back of the member's health plan ID card.

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

### Authorizations

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

### **Psychotherapy Notes Authorization**

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

Please find the most current copy of the Psychotherapy Notes Authorization form located online:

- Go to **anthem.com**. Select **Providers**, and **Provides Overview**. Select **Find Resources for Your State**, and pick **Colorado**. From the **Answers@Anthem** tab, select **Download Commonly Requested Forms**, and then select the link titled [Psychotherapy Notes Authorization](#).

### **Individual Authorization Form**

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

Please find the most current copy of the Individual Authorization Form located online:

- Go to **anthem.com**. Select **Providers**, and **Provides Overview**. Select **Find Resources for Your State**, and pick **Colorado**. From the **Answers@Anthem** tab, select **Download Commonly Requested Forms**, and then select the link titled [Individual Authorization Form](#).

### Detoxification

Detoxification services that can be appropriately managed in a behavioral health care substance abuse unit (the majority of all detoxification services) will be transferred to behavioral health care detoxification units and managed by Anthem's behavioral health

operations. Anthem medical management will manage acute detoxification cases that require acute medical beds based on co-morbid medical conditions such as severe cardiac arrhythmia, septicemia, electrolyte imbalance, GI bleeds, liver failure, diabetic coma, or other severe co-morbid condition.

### Utilization Management

- Facility utilization review representatives or intake representatives will transfer detoxification cases to behavioral health care units, and they'll contact Anthem's behavioral health operations UM department at **800-424-4014** for pre-certification.
- For acute medical situations that require admission to an acute medical bed detoxification unit, facility utilization review representatives will continue to call Anthem medical management at **800-832-7850**.
- **Note:** FEP UM, available toll free at **800-424-4011**, will continue to manage detoxification services for all FEP members.

### Anthem Behavioral Health Contact Information

Product Name	Reason for Call	Phone Numbers	Claims Submission Address	Prefix on Member ID Card
<b>Anthem Blue Cross and Blue Shield (Local Plan members)</b> Authorization not required for outpatient services	Intake/Authorization  Claims/eligibility/benefits	800-424-4014 <b>877- 833-5742</b>	Anthem Blue Cross and Blue Shield Claims P.O. Box 5747 Denver, CO 80217-5747	See <a href="#">Prefix Reference List</a>
<b>Health Insurance Marketplace/ACA:</b>  (This unit handles all Affordable Care Act (ACA) compliant plans which includes both on and off exchange plans)	Intake/Authorization  Claims/eligibility/benefits	800-424-4014  855-854-1438		See <a href="#">Prefix Reference List</a>
<b>FEP:</b> <b>FEP Standard</b> Authorization required for first outpatient visit <b>FEP Basic</b> Authorization required for first outpatient visit	Customer service/authorization  Claims/eligibility/benefits	800-424-4011  <b>800-852-5957</b>	FEP P.O. Box 105557 Atlanta, GA 30348-5557	R + 8 numerics



---

## Chiropractic, Acupuncture, Massage and Nutritional Therapy Services

Anthem is contracted with American Specialty Health (“ASH”) as of August 1, 2017 as its statewide provider for chiropractic, acupuncture, massage and nutritional therapy services. All ASH providers are listed on our provider directory at **anthem.com**. Provider demographic changes and Provider administrative grievances should be directed to ASH Healthcare for all lines of business at 800-972-4226.

### [PPO and Indemnity](#)

Members must use the ASH network to receive in-network coverage. Services **do not** require an authorization. Please contact Anthem for eligibility/benefits/claims information. **Please send claims to Anthem.** Please see the Telephone/Address Directory section for phone and address information.

### [HMO \(Chiropractic, Acupuncture and Massage Therapy\)](#)

Members must use the ASH network. Services don't require a referral but must be authorized by ASH. Please call ASH for eligibility/benefits/claims information at 800-972-4226. **Please send claims to ASH.**

**For Chiropractic, Acupuncture and Massage Therapy HMO claims, send to:**

American Specialty Health Group, Inc  
Attn: Claims Dept  
P.O. Box 509001  
San Diego, CA 92150-9001

**All claims for Nutritional Therapy (including HMO) should go directly to Anthem.**

---

## Workers' Compensation Program

### [Workers' Compensation](#)

Workers' compensation coverage is based on the philosophy that employers should provide employees with injury protection as a cost of doing business, and that benefits should be provided without regard to the at-fault party when an injury occurs during the course of employment. Anthem has created a network that will join together a group of health care professionals to provide medical care to injured workers. This approach

allows employees and members to essentially use the same network for both occupational and non-occupational treatment. Anthem's workers' compensation services unit will provide network access, to insurance companies, third-party administrators ("TPAs") and self-insured employers in Colorado. This can help employers control the health care costs of an injured worker's claim. If you participate in these networks, injured workers will be channeled to you for treatment via claims examiners or your listing in the online provider finder directory.

### [Provider Guidelines](#)

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

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

If a member is covered for workers' compensation benefits by a participating Other Payer who is a workers' compensation carrier permissibly, a self-insured employer contracting with Anthem seeks services for a work-related illness or injury, the provider has the following options:

- 1) provide such Medically Necessary medical services, or
- 2) refer the member to a health care professional that participates in the Anthem occupational medicine network. If the provider elects to treat the member, the provider must complete a Doctors First Report of Injury, as defined in the Workers' Compensation Act of Colorado.

As payment for the medical services rendered, the provider agrees to accept, as payment in full, compensation in accordance with the reimbursement set forth in the Agreement.

Send all workers' compensation-related correspondence to:

[awccustomerrelations@anthem.com](mailto:awccustomerrelations@anthem.com)  
PO BOX 25021, SANTA Ana, CA 92799

You can reach customer service for PPO contract pricing questions at 866-700-2168 or email customer relations at [awccustomerrelations@anthem.com](mailto:awccustomerrelations@anthem.com). Hours of operation are 5:30 am to 5:00 pm PST. Voice mail is available if you call this number after hours.

### [Utilization Management Guidelines](#)

The utilization management guidelines are those set by the Workers' Compensation Act of Colorado. If you have questions about these guidelines, please contact the Workers' Compensation Division. If you have questions about the utilization management process, please call us at 800-422-7334.

### [Workers' Compensation Act of Colorado Standards](#)

The Workers' Compensation Act of Colorado has established standards for injured workers for accessing care and guidelines to improve the quality of medical care for occupational injuries. Providers and Facilities must adhere to the following guidelines:

- Maintain medical control for the life of the claim.
  - Make referrals to providers in the participating and PPO occupational medicine network. To find providers in this network, you may search the online provider finder at:
    - <https://www.viiad.com/anthemcompass/BCCWCCO/app/home.asp>
    - Or call 866-700-2168.
- Services obtained outside the network may not be paid. Contact the claims adjuster for authorization for any medical care outside the network.
- After the initial visit, the injured worker can change to any physician of his or her choice within the network.
- Submit claims to the appropriate workers' compensation administrator as soon as possible after providing health care services. The Explanation of Review will indicate that rates are in accordance with your Anthem Agreement.
- Prohibit any surcharges or other billings in violation of the Labor Code for workers' compensation health care services.

The claims administrator will ensure payment for authorized medical services rendered while a claim is under investigation, until such time as the claims administrator denies the claim.

### [Anthem Workers' Compensation Payers Accessing the Participating and PPO Occupational Medicine Network](#)

For the most current list of participating payers, go to [anthem.com](http://anthem.com), select Plans and Benefits, and select the Workers' Compensation tab. We'll update this online list monthly, by the fifth of each month.



## Rules for Calculating Permanent Disability

The calculation of permanent disability is to be in accordance with the AMA Guides to the Evaluation of Permanent Impairment, 5<sup>th</sup> Edition. You can get Information about this guideline at [www.ama-assn.org](http://www.ama-assn.org).

If you feel you're unable to write the permanent and stationary report, contact the claims examiner to refer the patient to another physician to prepare a report utilizing the guideline.

## Grievances

A complaint and grievance process is available. Please contact us at: [AnthemWorkCompIncidents@anthem.com](mailto:AnthemWorkCompIncidents@anthem.com), or call 866-700-2168 for more information.

## Additional Information

For more information about the obligations of the treating physician for workers' compensation, go to the Colorado Division of Labor and Employment website at [www.coworkforce.com/dwc](http://www.coworkforce.com/dwc), or call us at 866-700-2168.

---

## **Glossary**

**Admission Notification** – Notice to the health plan about an urgent or emergent (unscheduled) admission

**anthem.com** – Anthem's website, where the Provider Policy and Procedure Manual can be viewed online

**Authorization** – Approval of benefits for a member's covered procedure or service

**Away from Home Care® Program** – Provides HMO members with health insurance coverage for urgent and emergent (life-threatening) medical services when an unforeseen illness or injury occurs while they're away from their Blue Cross and/or Blue Shield HMO plan's service area.

**Away from Home Care Program Guest Membership Benefit** – Health insurance coverage for HMO members from other Blue Cross and/or Blue Shield plans who are staying in Colorado temporarily (but more than three months). This coverage is available through HMO Colorado, and guest membership coverage is based on BlueAdvantage HMO guidelines and benefits.

**bcbs.com** – The Blue Cross and Blue Shield website, which providers and members can use to locate Providers or Facilities with any Blue Cross and/or Blue Shield plan.



This website is useful when a provider needs to refer a member to a provider in another location.

**BlueCard Access** – A toll-free telephone number, 800-810-BLUE (2583), Providers and members can call to locate providers contracted with any Blue Cross and/or Blue Shield plan. This number is useful when a provider needs to refer a member to a provider in another location.

**BlueCard Eligibility** – A toll-free telephone number, 800-676-BLUE (2583), Providers can call to verify membership and coverage information for members from other Blue Cross and/or Blue Shield plans.

**BlueCard HMO** – An out-of-area program available to members of Blue Cross and/or Blue Shield plan-sponsored HMOs. This program provides for urgent, emergent and pre-certified follow-up care.

**BlueCard PPO** – A national program that offers PPO-level benefits to members traveling or living outside their Blue Cross and/or Blue Shield plan's service area. They must obtain the services from a physician or hospital designated as a BlueCard PPO Provider.

**BlueCard PPO Member** – Members whose health plan ID card contains the “PPO in a suitcase” identifier. Only members with this identifier can access BlueCard PPO benefits

**BlueCard Program** – A national program that provides members with access to BlueCard providers and savings. The program enables members to obtain health care services while traveling or living in another Blue Cross and/or Blue Shield plan's area and to receive the same benefits as those under their contracting Blue Cross and/or Blue Shield plan. The program links participating health care providers and the independent Blue Cross and/or Blue Shield plans across the country through a single electronic network for claims processing and reimbursement. The program allows providers to submit claims for BlueCard members, including those located outside the United States, directly to the provider's local Blue Cross and/or Blue Shield plan.

**BlueCard Provider Finder Website ([www.bcbs.com](http://www.bcbs.com))** – A website providers and members can use to locate Providers and Facilities with any Blue Cross and/or Blue Shield plan. This website is useful when a provider needs to refer a member to a provider in another location.

**BlueCard Worldwide®** – A program that allows Blue Cross and/or Blue Shield members traveling or living outside the United States to receive inpatient, outpatient and professional services from Providers and Facilities worldwide. The program also allows members of international Blue Cross and/or Blue Shield plans to access Blue Cross and/or Blue Shield provider networks in the United States.

**Clinical Utilization Management (“UM”) Guideline** – Clinical UM Guidelines serve as one of the sets of guidelines for coverage decisions. These guidelines address the Medical Necessity of certain new medical services and/or procedures, or for new uses of existing medical 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.

Clinical UM guidelines may be developed to address the following:

- Medical necessity criteria for technologies or services where sufficient clinical evidence exists for evaluate the clinical appropriateness of the request
- Goal length of stay
- Place of service
- Level of care

**Concurrent Review** – Conducted to monitor ongoing care in an institutional setting to determine if clinical services and treatment plans continue to meet guidelines for the level of care the member is receiving

**Contractual Adjustment** – Any portion of a charge for a covered service that exceeds Anthem’s contracted allowed amount/maximum benefit allowance. Providers can’t charge contractual adjustments to members or to Anthem.

**Coordination of Benefits (“COB”)** – A stipulation in most health insurance policies that helps prevent duplicate payments for services covered by more than one insurance policy or program. The COB stipulation outlines which insurance organization has primary responsibility for payment and which insurance organization has secondary responsibility for payment.

**Electronic Data Interchange (“EDI”)** – The computer-application-to-computer-application exchange of business information in a standard electronic format. Translation software aids in exchange by converting data extracted from the application database into standard EDI format for transmission to one or more trading partners.

**Exclusive Provider Organization (“EPO”)** – A more rigid type of Health Maintenance Organization (HMO) health benefit program that provides benefits only if care is rendered by providers who belong to an identified network

**Experimental/Investigational –**

Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation or treatment of a disease, injury, illness or other health condition which we determine in our sole discretion to be experimental or investigational.

We will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply to be experimental or investigational if we determine that

one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought.

The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (“FDA”) or any other state or federal regulatory agency, and such final approval has not been granted
- Has been determined by the FDA to be contraindicated for the specific use
- Is provided as part of a clinical research protocol or clinical trial, or is provided in any other manner that is intended to evaluate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or is subject to review and approval of an Institutional Review Board (“IRB”) or other body serving a similar function
- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as experimental or investigational, or otherwise indicate that the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is under evaluation

(b) Any service not deemed experimental or investigational based on the criteria in subsection (a) may still be deemed to be experimental or investigational by us. In determining whether a service is experimental or investigational, we will consider the information described in subsection (c) and assess all of the following:

- Whether the scientific evidence is conclusory concerning the effect of the service on health outcomes
- Whether the evidence demonstrates that the service improves the net health outcomes of the total population for whom the service might be proposed as any established alternatives
- Whether the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings

(c) The information we consider or evaluate to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is experimental or investigational under subsections (a) and (b) may include one or more items from the following list, which is not all-inclusive:

- Randomized, controlled, clinical trials published in authoritative, peer-reviewed United States medical or scientific journal
- Evaluations of national medical associations, consensus panels and other technology evaluation bodies
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply

- Documents of an IRB or other similar body performing substantially the same function
- Consent documentation(s) used by the treating physicians, other medical professionals or facilities, or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply
- The written protocol(s) used by the treating physicians, other medical professionals or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply
- Medical records
- The opinions of consulting providers and other experts in the field

(d) We have the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is experimental or investigational.

**Health Benefit Plan** – The document(s) describing the partially or wholly insured, underwritten and/or administered health care benefits or services program between the plan and an employer, an individual, or a government or other entity; or, in the case of a self-funded arrangement, the plan document that describes the Covered Services for a member.

**Health Maintenance Organization (HMO)** – A health benefit program that offers benefits to members when they obtain services from the network of physicians and hospitals designated as HMO Providers and Facilities. Benefits are eliminated when the member obtains care from a non-HMO provider, except for emergency services and authorized referrals. Generally, HMO members select a primary care provider.

**HIPAA** – The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191

**Maximum Benefit Allowance (“MBA”)** – “Maximum Benefit Allowance” means the maximum amount of reimbursement allowed for a Covered Service as determined by Anthem.

**Medically Necessary or Medical Necessity** – means the definition set forth in the member's Health Benefit Plan, unless a different definition is required by statute or regulation.

**Medical Policy** – Medical Policies serve as one of the sets of guidelines for coverage decisions. Medical Policies address the Medical and/or Investigational policy position statements for certain indications that are objective and based on clinical evidence 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.

Medical policies may be developed to address the following:

- Experimental or investigational technologic (including a novel application of an existing technology)
- Services where there is a significant concern regarding member safety
- Medical Policy are implemented by all Plans

**Participating and PPO Occupational Medicine Network** – The network of health care providers, including facilities and ancillary providers, that have contracted with Anthem and/or one or more of its affiliates and other payers to provide compensable medical care for prospectively determined rates to injured workers.

**Participating and PPO Occupational Medicine Network Provider** – A facility, medical group practice, participating physician or other ancillary provider that has contracted with Anthem and/or one or more of its affiliates and other payers to provide compensable medical care for prospectively determined rates to injured workers.

**Pay, Paid or Payment** – to contractually settle a debt or obligation. After the maximum benefit allowance is determined, Anthem or the employer's benefit plan will satisfy its portion of the bill by payment to the provider. The member's portion of the payment includes a deductible, copayment and/or coinsurance, or other cost-sharing amounts, and, if the provider is non-participating, any amounts over the maximum benefit allowance. The amount Anthem pays a provider may not be the same as the allowable amount shown on the member's EOB or on the provider's bill.

**Pre-certification** – Authorization given before either an inpatient admission or outpatient procedure or service (a.k.a., prior authorization and/or pre-authorization)

**Preferred Provider Organization (PPO)** – A health benefit program under which members receive a higher level of benefits by receiving services from providers in an identified network.

**Prefix** – The three characters preceding the subscriber ID number on Blue Cross and/or Blue Shield health plan ID cards. The prefix is required for system-wide claims routing and identifies the member's Blue Cross and/or Blue Shield plan or national account.

**Pre-service Decision** – A review of medical care or services that Anthem conducts, in whole or in part, before a member obtains the medical care or services (e.g., prospective review). Pre-certification and pre-authorization are pre-service decisions.

**Post-service Decision** – Any review by Anthem of medical care or services already provided to a member (e.g., retrospective review).

**Primary Care Physician (“PCP”)** – A physician who has entered into a written Agreement with Anthem to provide Covered Services to members and to coordinate and arrange for the provision of other health care services to members who have selected the physician as their PCP. A PCP is defined as one of the following specialties, Pediatrician, Family Practice, General Practice and/or Internal Medicine.

**Prior Benefit Authorization (“PBA”)** – A determination made before a member receives certain services that meet all eligible-for-coverage criteria and that the services comply with the provisions of the member’s Health Benefit Plan.

**Provider** – A health care professional, institutional health care provider, ancillary provider, hospital or any other entity that has entered into a written Agreement with Anthem to provide Covered Services to members, including upon appropriate referral, if necessary, by the member’s PCP and/or Anthem. A non-participating provider is a provider who hasn’t entered into such an Agreement.

**Provider Policy and Procedure Manual** – Prepared by Anthem and which Anthem may amend solely at its discretion. This Manual sets forth the basic policies and procedures to be followed by providers in carrying out the terms and conditions of their Agreement with Anthem. The terms of the Provider Policy and Procedure Manual are part of such an Agreement.

**Prudent Lay Person Law** – State of Colorado Regulation 4-2-17, titled “Prompt Investigation of Health Plan Claims Involving Utilization Review”

**Referral** – Authorization given to a member by the member’s PCP for an office visit with another provider. Referrals don’t cover procedures performed outside the provider’s office or invasive procedures performed in the provider’s office.

**Reimbursement Policy** – Reimbursement Policies are a set of policies developed to document coding and pricing methodologies as well as clinical editing for certain specific services.

**Retrospective Review** – Conducted to evaluate the appropriateness of services and level of care after services have been rendered. Review may occur before or after the initial payment determination.

**Subscriber Liability** – The amount the subscriber (member) must pay the provider, such as deductibles, coinsurance and copayments, to satisfy contractual cost-sharing obligations.

**Utilization Review** – A set of formal techniques designed to monitor the use, or evaluate the clinical necessity, appropriateness, efficacy or efficiency, of health care services, procedures or settings. Techniques include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning and/or retrospective review. Utilization review also includes reviews to

determine coverage. This is based on whether or not a procedure or treatment is considered experimental/investigational in a given circumstance (except if it's a specific exclusion under the member's Health Benefit Plan) and review of a member's medical circumstances when necessary to determine if an exclusion applies in a given situation.

---

## Exhibits

### [Download Commonly Requested Forms](#)

Download our commonly requested forms online. Go to **anthem.com**. Select **Providers**, and **Provides Overview**. Select **Find Resources for Your State**, and pick **Colorado**. From the **Answers@Anthem** tab, [Download Commonly Requested Forms](#). Downloads forms such as the following:

- **Additional Information Requested Form**
- **Blue Priority Referral Form**
- **Claim Action Request Form**
- **Coordination of Benefits (COB) Questionnaire**
- **Designation of an Authorized Representative (DOR Form)**
- **Fax Authorization Form**
- **Health Delivery Organization (HDO)/Facility Application**
- **Individual Authorization Form**
- **Medicare Advantage General Precert Form**
- **Medical-Surgical Clinical Data Submission**
- **Member Liability Waiver Form**
- **Provider Maintenance Form**
- **Provider Dispute Resolution Form**
- **Provider Refund Adjustment Request**
- **Psychotherapy Notes Authorization Form**
- **Therapy Providers (PT/OT/ST) Roster Update – Colorado**
- **Urgent Care or Walk-In Doctor's Office Information**
- **W-9 Form**

---

## Appendices

---

### Links

[BlueCard® Website](#)

[Centers of Medical Excellence \(“CME”\)](#)

[Contact Us](#)

[Federal Employee Program \(“FEP”\) Website](#)

[List of Affiliates](#)

[Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements](#)

[Medicare Advantage](#)

---