Provider Guidebook

Medicare Advantage

Anthem®

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1 MEDICARE OVERVIEW

1.1 Medicare Program

The Centers for Medicare & Medicaid Services (CMS) administers Medicare, the nation's largest health insurance program, which covers over 40 million Americans. Medicare is a health insurance program for people 65 years of age and older, some disabled people under 65 years of age, and people with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant). Original Medicare is divided into two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). Part A helps pay for care in a hospital, skilled nursing facility, home health care, and hospice care. Part B helps pay doctor bills, outpatient hospital care and other medical services not covered by Part A.

1.2 Part A

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

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

1.3 Part B

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

- Outpatient hospital services.
- X-rays and laboratory tests.
- Certain ambulance services.
- DME.
- Services of certain specially qualified, nonphysician practitioners.
- Physical and occupational therapy.
- Speech/language pathology services.
- Partial hospitalization for mental health care.
- Mammograms and Pap tests.
- Home Health care if a beneficiary does not have Part A.

1.4 Medicare Advantage Plans

The Balanced Budget Act of 1997 (*BBA*) established Medicare Part C also referred to as Medicare Advantage (MA). Prior to January 1, 1999, Medicare Health Maintenance Organizations (HMOs) existed as Medicare Risk or Medicare Cost plans. The *Balanced Budget Act of 1997* was intended to increase the

range of alternatives to the traditional fee-for-service program for Medicare beneficiaries. The options included Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs).

1.5 Medicare HMO

Anthem Blue Cross and Blue Shield (Anthem) contracts with a network of hospitals, skilled nursing facilities, home health agencies, doctors and other professionals to provide services to our members. Anthem Medicare Advantage HMO members must select a PCP from those that are part of the plan's network. The PCP is responsible for managing the member's medical care, including admissions to a hospital. The member's PCP is also responsible for referring the member to a specialist. PCPs should refer the member to an in-network specialist and note the referral in the member's chart. PCPs are not required to notify the plan of the referral.

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

1.6 Medicare Local PPO

The Anthem local PPO plan is a managed care plan in which members pay less out-of-pocket costs when they use providers who are part of the Anthem Medicare Advantage PPO network. Local PPOs are available in select counties within a state. CMS allows the Medicare Advantage plan to select the counties they want to participate in. Anthem has a contract with the federal government that allows Anthem to administer all Medicare benefits. Medicare Advantage PPO members are strongly encouraged, but not required, to select a PCP. MA PPO members are also not required to obtain a referral for specialty care but should coordinate with their PCP. Anthem Medicare Advantage PPO members can use providers both in and out of the network. Precertification is required for some services.

1.7 Medicare Regional PPO

CMS requires Anthem to offer a Regional PPO in all counties within the designated CMS-defined region. A Regional PPO is also a managed care plan in which members pay less out-of-pocket costs when they use providers who are part of the Anthem Regional PPO network. Anthem Regional PPO members are not required to select a PCP or obtain a referral for specialty care. Members are encouraged to coordinate their care through a PCP. Anthem Medicare Advantage PPO members can use providers both in and out of the network. Precertification is required for some services.

1.8 Managed Care Plan Enrollment

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

- Have Medicare Parts A and B and continue paying Part B premiums.

- Live in the plan's service area.
- Not have permanent kidney failure at the time of enrollment unless they are currently enrolled in the plan's commercial product.

The plan must enroll Medicare beneficiaries, including younger disabled Medicare beneficiaries, in the order of application, without health screening. Medicare Advantage plans are required to have an open enrollment period from October 15 through December 7 each year, with a January 1 plan effective date.

Special Election Period
CMS has identified several circumstances under which a person may change Medicare options outside of the annual or initial enrollment periods. For example, Medicare beneficiaries who are also eligible for Medicaid can enroll in or disenroll from Medicare Advantage plans throughout the year.

Note: Special Needs Plan (SNP) enrollees may change Medicare Advantage plans at any time during the year with changes effective the first of the following month, subject to CMS approval.

1.9 Medicare Dual Eligible Special Needs Plans

Dual Eligible SNPs (D-SNPs) enroll beneficiaries who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Plan under Title XIX (Medicaid), and offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid. D-SNPs are open to beneficiaries in all Medicaid eligibility categories including: Qualified Medicare Beneficiary without other Medicaid (QMB only), QMB+, Specified Low-Income Medicare Beneficiary without other Medicaid (SLMB only), SLMB+, Qualifying Individual (QI), Other full benefit dual eligible (FBDE) and Qualified Disabled and Working Individual (QDWI).

Although D-SNPs are available to beneficiaries in all Medicaid eligibility categories, D-SNPs may further restrict enrollment to beneficiaries that belong to certain Medicaid eligibility categories. CMS divides D-SNPs into the following two categories according to the types of beneficiaries that the SNP enrolls:
- Medicare zero-cost-sharing D-SNPs
- Medicare non-zero cost-sharing D-SNPs

1.10 Medicare Chronic Condition Special Needs Plans

Chronic Condition Special Needs Plans (C-SNPs) restrict enrollment to special needs individuals with specific severe or disabling chronic conditions. C-SNPs focus on monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations and helping beneficiaries move from high risk to lower risk on the care continuum. CMS has approved 15 SNP-specific chronic conditions for which C-SNPs can target enrollment.

1.11 Anthem Individual Medicare Advantage Plans

Below is a link to the Medicare Advantage *Summary of Benefits* (*SOB*), *Evidence of Coverage* (*EOC*) and formularies for Individual Medicare Advantage Products. If the product you are searching for is not on the list below, please call the number on the back of the member's ID card for *EOC*, *SOB*, and formulary information **https://www.anthem.com/medicareprovider.**

Supplemental Benefits
Our Medicare Advantage HMO and PPO plans may include supplemental benefits. Supplemental benefits are items or services that are not covered under Medicare Part A, Part B or Part D but are covered by the

plan in addition to what Medicare covers. Please refer to each plan's benefit materials to locate any supplemental benefit coverage. Most supplemental benefits are required to be rendered by providers within the vendor network associated with that supplemental benefit or they are considered noncovered benefits.

Providers **contracted with the vendor network** associated with that supplemental benefit must bill that vendor directly. Providers **not contracted with the vendor network** to render such a benefit will only be reimbursed or able to bill a member for noncovered services if:

- For an HMO member, you have provided the member with advanced notice of noncoverage. Please note that contracted providers are required to provide a coverage determination for services that are not covered by the member's MA plan. This will ensure that the member will receive a denial of payment and accompanying appeal rights. Per the *Medicare Advantage HMO & PPO Provider Guidebook*, CMS has stated that the use of an *Advanced Beneficiary Notice* or a similar document is not sufficient in many instances with Medicare Advantage members. Therefore, you are required to seek a coverage determination prior to rendering such services.
- For a PPO member, providers notify the member up front that they are not contracted for the Supplemental Benefit and therefore out-of-network cost share will apply.

Providers are encouraged to call the toll free customer service number on the back of the member ID card with any questions around services that may or may not be covered.

1.12 Effective/Termination Date Coincides with a Hospital Stay

If a member's effective date occurs during an inpatient stay in a hospital, Anthem is not responsible for any services under Medicare Part A during the inpatient stay. (This provision applies to acute hospital stays only, not to stays in a Skilled Nursing Facility.

Anthem is responsible for inpatient hospital services under Part A on the day after the day of discharge from the inpatient stay. All other services, other than inpatient hospital services under Part A, are covered by the Medicare Advantage plan beginning on the effective date of enrollment.

If the member's Medicare Advantage coverage terminates while the members is hospitalized, Anthem is responsible for the facility charges until discharge regardless of the reason for the coverage termination.

1.13 Hospice Election for Medicare Advantage (MA) Members

Members may elect Medicare hospice coverage if they have a terminal illness and meet the appropriate guidelines. Hospice care emphasizes supportive services, such as home care and pain control, rather than cure-oriented services. It also includes physical care and counseling.

When a Medicare Advantage (MA) member elects to enroll in the Medicare Hospice Program, Original Medicare assumes responsibility for payment of all hospice-related and all non-hospice related services rendered during the election period. The Medicare Advantage plan is responsible for supplemental services covered under the member's MA plan and coordinates benefits for the original Medicare deductible and coinsurance amounts applied so that it does not exceed the MA plan cost-share amount. CMS released CR6778 to clarify that this change in financial responsibility begins on the day of Hospice Election.

The following are submission guidelines for Hospice claims:

Hospice-related Services

- Submit the claim directly to CMS

Nonhospice-related Services

- For Part A services not related to the member's terminal condition, submit the claim to the Medicare Fiscal Intermediary using the condition code 07.
- For Part B services not related to the member's terminal condition, submit the claim to the Medicare Carrier with a "GW" modifier.
- For services rendered for the treatment and management of the terminal illness by an attending physician that is not employed or paid by the hospice provider, submit the claim to the Fiscal Intermediary/Medicare Carrier with a "GV" modifier.

Coordination of Member Cost-Share Amount and Supplemental Benefits

- Submit the claim to the Medicare Advantage Plan with the Original Medicare Explanation of Medicare Benefits (EOMB).

Note: The Anthem MA plan will coordinate based on the EOMB in the situation where the MA plan liability if the member cost sharing is less than the MA plan cost-share amount. Please submit the claim with the EOMB for consideration.

For additional detail on hospice coverage and payment guidelines, please refer to 42 CFR 422.320 — Special Rules for Hospice Care. Section (C) outlines the Medicare payment rules for members who have elected hospice coverage. The Medicare Benefit Policy Manual Publication 100-02 Chapter 9 Coverage of Hospice Service Section 20.4 Election by Managed Care Enrollee; Medicare Managed Care Manual Publication 100-16 Chapter 4 Benefits and beneficiary Protections Sections 10.22 – 10.4 and the CMS Change Request 8727 dated May 1, 2014, all-outline payment responsibility and billing requirements for services rendered during a hospice election period. This documentation is available online at the CMS website: **http://cms.gov**.

2 PROVIDER PARTICIPATION IN ANTHEM MA PLANS

2.1 Participation Procedures for Physicians and Physician Group(s)

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

a. Written notice of rules of participation
b. Written notice of material changes in participation rules before they become effective
c. Written notice of adverse participation changes, and
d. Process for appealing adverse physician participation decisions

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

Provider agrees that in no event, including but not limited to nonpayment by plan, insolvency of plan or breach of the Agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered individual or persons other than plan acting on their behalf for covered services provided pursuant to the Agreement. This section does not prohibit the collection of supplemental charges or cost shares on plan's behalf made in accordance with the terms of the covered individual's health benefit plan or amounts due for services that have been correctly identified in advance as a noncovered service, subject to medical coverage criteria, with appropriate disclosure to the covered individual of their financial obligation. This advance notice must satisfy the CMS regulations for Medicare Advantage organizations, which currently requires a provider to provide to covered individuals a coverage determination that includes CMS-mandated appeal rights. Both parties agree that failure to follow the CMS regulations will result in a provider's financial liability.

A provider further agrees that for covered individuals who are dual eligible enrollees for Medicare and Medicaid, that a provider will ensure they will not bill the covered individual for cost sharing that is not the covered individual's responsibility and such covered individuals will not be held liable for Medicare Parts A and B cost sharing when the state is liable for the cost sharing. In addition, provider agrees to accept the plan payment as payment in full or by billing the appropriate state source.

CMS has stated that the use of an *Advanced Beneficiary Notice* or a similar document is not sufficient in many instances with Medicare Advantage members. Providers are encouraged to call the toll-free customer service number with any questions around services that may or may not be covered.

Note: Members that are dually eligible, either as full benefit dual eligible or as part of a Medicare Savings Program, are protected from liability of Medicare premiums, deductible, coinsurance and copayment amounts. This includes cost share being applied to this/these claims. Providers may not bill a dual eligible that has this coverage for any balance left unpaid (after submission to Medicare, a Medicare carrier and subsequently Medicaid) as specified in the *Balanced Budget Act of 1997*. Providers that service dual eligible beneficiaries must accept as payment in full the amounts paid by Medicare as well as any payment under the state Medicaid processing guidelines. Providers who balance bill the dual eligible beneficiary are in violation of these regulations and are subject to sanctions. Providers also may not accept dual eligible beneficiaries as 'private pay' in order to bill the patient directly and providers identified as continuing to bill dual eligible beneficiaries inappropriately will be reported to the CMS for further action/investigation.

2.2 Terminating Participation with Anthem Medicare Advantage Plans

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

Any provider requesting termination of his/her participation should send written notification to the Anthem Network Management Department in his/her region. Upon receipt of the termination request, Anthem will send a written, CMS-approved notification of the termination to all affected members at least 30 calendar days before the effective date of termination. MA organizations that suspend or terminate a contract due to deficiencies in the quality of care must give notice of that action to the licensing or disciplinary bodies.

2.3 Termination of a Provider Contract with Cause

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

- Reason for the action
- Standards and the profiling data used to evaluate the health care professional when applicable
- Mix of health care professionals the organization needs when applicable
- Affected health care professional's right to appeal the action and the process and timing for requesting a hearing.

The composition of the hearing panel must ensure that the vast majority of the panel members are peers of the affected health care professional. A Medicare Advantage organization that suspends or terminates a contract with a health care professional due to deficiencies in the quality of care must give written notice of that action to licensing, disciplinary, or other appropriate authorities.

2.4 Termination of a Provider Contract without Cause

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

2.5 Provider Anti-discrimination Rules

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

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

2.6 Compliance with Medicare Laws, Audits and Record Retention Requirements

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

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

In addition to the obligation to safeguard the privacy of any information that identifies a Medicare Advantage member, Anthem and providers 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.

First tier and downstream providers must agree to comply with Medicare laws, regulations, and CMS instructions (422.504(I)(4)(v)). First tier and downstream providers must also agree to inspections, evaluations and audits by CMS and/or its designees and to cooperate, assist, and provide information as requested **and** must maintain records for a minimum of 10 years.

For the purposes specified in this section, providers must agree to make available its premises, physical facilities and equipment, records relating to the MA Organization's members, including access to provider's computer and electronic system and any additional relevant information that CMS may require.

Providers acknowledge that failure to allow the Department of Health and Human Services, the Comptroller General or their designees the right to timely access as addressed in this section may result in a $15,000 noncompliance penalty.

2.7 Encounter Data

Each Medicare Advantage organization must submit to CMS all data necessary to characterize the context and purpose of each encounter between a Medicare enrollee and a provider, supplier, physician, or other practitioner. Provider services must be submitted by the Medicare Advantage organization for all the services provided by the network and nonnetwork physicians and nonphysician practitioners.

Encounter data shall conform with and include all information necessary for the Medicare Advantage Organization to submit data to CMS in accordance with applicable CMS and federal requirements, including but not limited to all HIPAA requirements that may be imposed upon a Medicare Advantage organization and provider.

If the provider fails to submit encounter data accurately, completely and truthfully, in the format described in 42 CFR 422.257, then this will result in denials and/or delays in payment of the provider's claims.

In addition, the provider has contractually agreed to certify the accuracy, completeness and truthfulness of the provider's generated encounter data that the Medicare Advantage Organization is obligated to submit to CMS. No later than 30 days after the beginning of every fiscal year while the Medicare Advantage participation is in effect, the provider agrees to certify the accuracy, completeness, and truthfulness of the provider's encounter data submitted during the specific period. This certification shall be provided in writing and in the specified format at the request of the Medicare Advantage Organization.

2.8 Encounter Data for Risk Adjustment Purposes

Risk Adjustment and Data Submission

Risk adjustment is the process used by CMS to adjust the payment made to the Medicare Advantage Organization based on the health status of the Medicare Advantage Organization's Medicare Advantage members. Risk adjustment was implemented to pay Medicare Advantage 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. As an MA organization, diagnosis data collected from encounter and claim data is required to be submitted to CMS for purposes of risk adjustment. Because CMS requires that Medicare Advantage Organizations submit "all ICD-10 codes for each beneficiary", Anthem also collects diagnosis data from the members' medical records created and maintained by the provider.

Under the CMS risk adjustment model, the Medicare Advantage Organization is permitted to submit diagnosis data from inpatient hospital, outpatient hospital and physician encounters only.

Risk Adjustment Data Validation (RADV) Audits

As part of the risk adjustment process, CMS will perform an RADV audit in order to validate the MA members' diagnosis data that was previously submitted by Medicare Advantage Organizations. These audits are typically performed once a year. If the Medicare Advantage Organization is selected by CMS to participate in a RADV audit, the Medicare Advantage Organization and the providers that treated the MA members included in the audit will be required to submit medical records to validate the diagnosis data previously submitted.

ICD-10-CM Codes

CMS requires that physicians currently use the ICD-10-CM Codes (ICD-10 Codes) and coding practices for Medicare Advantage business. In all cases, the medical record documentation must support the ICD-10 Codes selected and substantiate that proper coding guidelines were followed by the provider. For example, in accordance with the guidelines, it is important for physicians to code all conditions that coexist at the time of an encounter and that require or affect patient care or treatment. In addition, coding guidelines require that the provider code to the highest level of specificity which includes fully documenting the patient's diagnosis.

Medical Record Documentation Requirements (Risk Adjustment)

Medical records significantly impact risk adjustment because:

- They are a valuable source of diagnosis data;
- They dictate what ICD-10 Code is assigned;
- They are used to validate diagnosis data that was previously provided to CMS by the Medicare Advantage Organization.

Because of this, the provider plays an extremely important role in ensuring that the best documentation practices are established.

CMS 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).
- The documentation describing the condition and MEAT 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 signature, credentials and date must appear on record and must be legible.

2.9 Medical Record Review Process

Anthem has medical record standards that require practitioners to maintain medical records in a manner that is current, organized and facilitates effective and confidential member care and quality review. Anthem performs medical record reviews to assess network PCPs in relation to current medical record standards. Anthem recognizes the importance of medical record documentation in the delivery and coordination of quality care and requires practitioners to comply with the plans' standards for medical record documentation.

Medical record audits/reviews are performed annually on a %age of randomly chosen PCPs contracted for the plans' managed care products for Medicare Advantage networks. For purposes of medical record audits/reviews, a PCP is defined as family medicine, general medicine, internal medicine, pediatrics and obstetrics/gynecology (when acting as a PCP). A random sampling of these PCPs is identified in the current year and abstracted from the HEDIS® data collection process.

In order to pass the audits/reviews, an office must attain an overall score of 80% or greater on the medical record audit. If a practitioner fails to meet a plan's standard of 80%, a re-review is conducted within six months. Should the practitioner continue to score less than 80% on the medical record review, the practitioner would be put on corrective action that could result in termination from the network.

Medical Record Criteria

The medical record will be evaluated for the following criteria:

1. Every page in the record contains the patient name or ID number.
2. Allergies/NKDA and adverse reactions are prominently displayed in a consistent location.
3. All presenting symptom entries are legible, signed, and dated, including phone entries. Dictated notes should be initialed to signify review. Signature sheet for initials are noted.
4. A problem list is maintained and updated for significant illnesses and medical conditions.
5. A medication list or reasonable substitute is maintained and updated for chronic and ongoing medications.
6. History and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting symptoms, and treatment plan is consistent with findings.
7. Laboratory tests and other studies are ordered, as appropriate, with results noted in the medical record. (The clinical reviewer should see evidence of documentation of appropriate follow-up recommendations and/or noncompliance to care plan).
8. Documentation of advance directive/Living Will/Power of Attorney discussion in a prominent part of the medical record for adult patients who are MA members; and documentation on whether or not the patient has executed an advance directive with a copy to be included in the medical record. (We also encourage providers to maintain documentation of advance directive discussions and copies of executed advance directives in patients' files for other, non-MA members.)
9. Continuity and coordination of care between the PCP, specialty physician (including BH specialty) and/or facilities if there is reference to referral or care provided elsewhere. The clinical reviewer will look for a summary of findings or discharge summary in the medical record. Examples include progress notes/reports from consultants, discharge summary following inpatient care or outpatient surgery, physical therapy reports, and home health nursing provider reports.

10. Age appropriate routine preventive services/risk screenings are consistently noted, (in other words, childhood immunizations, adult immunizations, mammograms, Pap tests, etc., or the refusal by the patient, parent or legal guardian, of such screenings/immunizations in the medical record.

2.10 Federal Funds

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

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

2.11 Prompt Payment by Medicare Advantage (MA) Organization

Receipt of claims by noncontracted providers will be considered a “clean claim” if it contains all necessary information for the purposes of encounter data requirements and complies with the requirement for a clean claim under fee-for-service Medicare. The MA organization is bound to adhere to the following prompt payment provisions for noncontracted providers:

- Pay 95%of clean claims within 30 days of receipt
- Pay interest on clean claims not paid within 30 days
- All other claims must be approved or denied with 60 calendar days from date of receipt

All contracted providers must include a prompt payment provision in their contract, the terms of which are developed and agreed to by the MA organization and the provider. Claims with incomplete or inaccurate data elements will be returned with written notification of how to correct and resubmit the claim. Claims that need additional information in order to be reprocessed will be suspended and a written request for the specific information will be sent to the provider. If the requested information is not received within the specified time frame, the claim will be closed and the provider will be notified.

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

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

If you are a contracting provider, please refer to you contract for the prompt payment terms applicable to you.

2.12 Billing Members and Balance Billing

Cost-Sharing

An important protection for beneficiaries when they obtain plan-covered services in an HMO, PPO, or RPPO is that they do not pay more than plan-allowed cost sharing. Providers who are permitted to balance bill must obtain this balance billing from the Medicare Advantage Organization (MAO). Providers may **not** collect any additional payment for cost-sharing obligations from Medicare members other than those specified in a member's plan *Summary of Benefits*.

Cost-Sharing Responsibility for Special Needs Plan Members

Members that are dually eligible, either as full benefit dual eligible or as part of a Medicare Savings Program, are protected from liability of Medicare premiums, deductible, coinsurance and copayment amounts. This includes cost share being applied to this/these claims. Providers may not bill a dual eligible that has this coverage for any balance left unpaid (after submission to Medicare, a Medicare carrier and subsequently Medicaid) as specified in the *Balanced Budget Act of 1997*. Providers that service dual eligible beneficiaries must accept as payment in full the amounts paid by Medicare as well as any payment under the state Medicaid processing guidelines. Providers who balance bill the dual eligible beneficiary are in violation of these regulations and are subject to sanctions. Providers also may not accept dual eligible beneficiaries as 'private pay' in order to bill the patient directly and providers identified as continuing to bill dual eligible beneficiaries inappropriately will be reported to CMS for further action/investigation. Anthem processes the claim for reimbursement when Anthem has an arrangement with state Medicaid to pay Medicare cost sharing for dual-eligible members in its Special Needs Plans (SNP). The state retains responsibility for cost sharing when Anthem does not have an arrangement with the state Medicaid agency. In states where Anthem pays cost sharing, claims will be processed under the member's account for both Medicare and Medicaid benefits. In the states where Anthem does not have an arrangement with the state Medicaid agency, providers should bill cost sharing to the appropriate Medicaid carrier or state Medicaid agency for payment once the claim has been processed by Anthem. Please check your *EOP* upon claims adjudication.

Note: Under Original Medicare rules, an Original Medicare participating provider (hereinafter referred to as a participating provider) is a provider that signs an agreement with Medicare to always accept assignment. Participating providers may never balance bill because they have agreed to always accept the Medicare allowed amount as payment in full. An Original Medicare nonparticipating provider (hereinafter referred to as a nonparticipating, or non-par, provider) may accept assignment on a case-by-case basis and indicates this by checking affirmatively field 27 on the *CMS-5010* claims form; in such a case, no balance billing is permitted.

The rules governing balance billing as well as the rules governing the MA payment of MA plan, noncontracting and Original Medicare, nonparticipating providers are listed below by type of provider.

Contracted provider

There is no balance billing paid by either the plan or the enrollee.

Noncontracting, Original Medicare, participating provider

There is no balance billing paid by either the plan or the enrollee.

Noncontracting, non-(Medicare)-participating provider

The MAO owes the noncontracting, nonparticipating (non-par) provider the difference between the members' cost-sharing and the Original Medicare limiting charge, which is the maximum amount that Original Medicare requires an MAO to reimburse a provider. The enrollee only pays plan-allowed cost-sharing, which equals:

- The copay amount, if the MAO uses a copay for its cost-sharing; or
- The coinsurance %age multiplied by the limiting charge, if the MAO uses a coinsurance method for its cost-sharing.
- MA-plan, noncontracting, nonparticipating DME supplier. The MAO owes the noncontracting nonparticipating (non-par) DME supplier the difference between the member's cost-sharing and the DME supplier's bill; the enrollee only pays plan allowed cost-sharing, which equals:
  - The copay amount, if the MAO uses a copay for its cost-sharing; or
  - The coinsurance %age multiplied by the total provider bill, if the MAO uses a coinsurance method for its cost-sharing. Note that the total provider bill may include permitted balance billing.

Additional useful information on payment requirements by MAOs to nonnetwork providers may be found in the "*MA Payment Guide for Out of Network Payments*," at **http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/downloads/oon-payments.pdf.**

MA plans must clearly communicate to enrollees through the *Evidence of Coverage* (*EOC*) and *Summary of Benefi*ts (SOB) their cost-sharing obligations as well as their lack of obligation to pay more than the allowed plan cost-sharing as described above.

If you are a noncontracting, nonparticipating (Medicare) provider, who does not accept Medicare assignment, please contact us if there are any questions regarding your claim(s) payments.

Loss of Medicaid Coverage for Special Needs Plan Members
Anthem D-SNP (Dual Eligible Special Needs Plan) members are dual-eligible beneficiaries with both Medicare and Medicaid benefits, or they have Medicare and are considered Qualified Medicare Beneficiaries (QMB or QMB+). Medicare members who do not receive full Medicare cost share assistance under Medicaid may be required to pay cost sharing and copayments for services. Members are encouraged to be cognizant of their eligibility to ensure there is no loss or gap in coverage that would result in liability of cost share.

Note: If the Part A deductible and Part B deductible are not already met at the time of the beneficiary's loss of coverage, the member will be responsible for the extended Length Of Services (LOS) per diem cost share for inpatient facilities and/or any coinsurance on professional and outpatient services

Recovery Look-Back Period
To align with CMS guidelines, 42 CFR § 405.980, 405.986, Anthem recovers Medicare Advantage claim overpayments within four years of the claim payment date.
In addition, CMS' Medicare Integrity Program employs Recovery Audit Contractors to identify and correct improper Medicare payments. The RAC program allows for a look-back period of up to five years.

The appeals process remains unchanged.

2.13 Recoupment/Offset/Adjustment for Overpayments of Contracting Providers

Anthem shall be entitled to offset and recoup an amount equal to any overpayments or improper payments made by Anthem to a provider against any payments due and payable by Anthem to a provider under the *Participating Provider Agreement*. The provider shall voluntarily refund all duplicate or erroneous claim payments regardless of the cause, including, but not limited to, payments for claims

where the claim was miscoded, noncompliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by Anthem that any recoupment, improper payment, or overpayment is due from a provider, provider must refund the amount to Anthem within 30 days of when Anthem notifies a provider. If such reimbursement is not received by Anthem within the 30 days following the date of such notice, Anthem shall be entitled to offset such overpayment against other amounts due and payable by Anthem to a provider in accordance with regulatory requirements. Anthem reserves the right to employ a third-party collection agency in the event of nonpayment.

2.14 Use of Anthem trademark within communications

Anthem welcomes you to use our name and logo along with other information, such as how a person may contact us, when you send out communications to you patients. In order to use the Anthem name or logo within a communication, a provider must first obtain permission from Anthem as noted within your provider contract. Our provider contracts stipulate that any printed materials, including but not limited to letters to plan-covered persons, brochures, advertisements, telemarketing scripts, packaging prepared or produced by a provider or any of his/her/its subcontractors pursuant to this *Participating Provider Agreement* must be submitted to the plan to assure compliance with federal, state, and Blue Cross/Blue Shield Association guidelines. Anthem agrees its approval will not be unreasonably withheld or delayed. In order to make this easier on you the provider, we have simplified the submission of the document(s) to Anthem for review.

To submit a document for review, please send the copy to your local Provider Relations Consultant. Once the copy is submitted it will be the responsibility of your local Provider Relations Consultant to insure that the internal Anthem legal review is completed in a timely manner. Although the Anthem legal team will be reviewing the copy, it is your responsibility to comply, and to require any of your subcontractors to comply, with all applicable federal and state laws, regulations, CMS instructions, and marketing activities under this *Participating Provider Agreement,* including but not limited to, the *National Marketing Guide* for Medicare Managed Care Plans, and any requirements for CMS prior approval of materials. We again welcome you to use our name and logo when you send out communications to you patients in an effort to provide information to your patients.

2.15 PPO Provider Network Sharing

Network sharing allows MA PPO members from MA PPO Blue Plans to obtain in-network benefits when traveling or living in the service areas of the MA PPO Plans as long as the member sees a provider contracted with a Blue Medicare Advantage PPO plan in one of the areas listed below. Medicare Advantage PPO shared networks are available in 32 states and one territory:

Alabama	Arkansas	California	Colorado	Connecticut	Florida
Georgia	Hawaii	Idaho	Indiana	Kentucky	Maine
Massachusetts	Michigan	Missouri	N. Carolina	Nevada	New Hampshire
New York	Ohio	Oregon	Pennsylvania	Puerto Rico	S. Carolina
Tennessee	Utah	Virginia	Washington	Wisconsin	West Virginia
Montana	New Mexico	Oklahoma			

If you are a contracted MA PPO provider with Anthem and you see MA PPO members from other Blue Plans, these members will be extended the same contractual access to care and will be reimbursed in accordance with your negotiated rate with your Anthem contract. These members will receive in-network benefits in accordance with their member contract.

If you are not a contracted MA PPO provider with Anthem and you provide services for any Blue Medicare Advantage members, you will receive the Medicare allowed amount for covered services. For urgent or emergency care, you will be reimbursed at the member's in-network benefit level. Other services will be reimbursed at the out-of-network benefit level.

You can recognize a MA PPO member when their Blue Cross Blue Shield Member ID card has the following logo.

The "MA" in the suitcase indicates a member who is covered under the MA PPO network sharing program. Members have been asked not to show their standard Medicare ID card when receiving services; instead, members should provide their Blue Cross and/or Blue Shield member ID.
If you are a contracted Medicare Advantage PPO provider with Anthem, you must provide the same access to care as you do for the Anthem Blue MA PPO members. You can expect to receive the same contracted rates for such services.

If you are not a Medicare Advantage PPO contracted provider, you may see Medicare Advantage members from other Blue Plans but you are not required to do so. Should you decide to provide services to Blue Medicare Advantage members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. For urgent or emergency care, you will be reimbursed at the in-network benefit level.
If your practice is closed to new local Blue MA PPO members, you do not have to provide care for Blue MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members as your local MA PPO members.

To verify a member's eligibility, call the BlueCard Eligibility Line at **1-800-676-BLUE** (**1-800-676-2583**) and provide the member's three-digit alpha prefix located on the ID card.

You should submit claims to Anthem under your current billing practices. If you are a MA PPO contracted provider with Anthem, benefits will be based on your contracted MA PPO rate for providing covered services to MA PPO members from any MA PPO Plan. Once you submit the MA claim, Anthem will work with the other plan to determine benefits and send you the payment. When you provide covered services to other Blue Medicare Advantage out-of-area members, benefits will be based on the Medicare allowed amount. Once you submit the MA claim, Anthem will send you the payment. However, these services will be paid under the member's out-of-network benefits unless for urgent or emergency care.
A MA PPO member cost sharing level and copay is based on the member's health plan. You may collect the copay amounts from the member at the time of service. To determine the cost sharing and/or copay amounts, you should call the BlueCard Eligibility Line at **1-800-676-BLUE** (**1-800-676-2583**).You may not balance bill the member for this difference. Members may be balance billed for any deductibles, co-insurance, and/or copays. If there is a question concerning the reimbursement amount or questions regarding any part of the MA PPO network sharing, contact Anthem at the number on the back of the member's ID card.

2.16 Contracted Provider Assistance with Medicare Advantage Material

As part of the Anthem goal to improve the health of the senior community, we are committed to providing them with the facts about our Medicare Advantage health care plans that help seniors make more informed decisions about their health care and coverage needs. To assist with meeting the goal to keep Medicare beneficiaries more informed, we need your help. Anthem would like to make Medicare Advantage materials available to beneficiaries through our contracted providers. We are asking your permission to display Medicare Advantage materials in your offices. Our sales representatives will be contacting you and other contracted providers to work with Anthem to provide this information to beneficiaries.

Your participation with this request is strictly voluntary; However, as with all provider-based activities, CMS has certain requirements for both the Medicare Advantage sponsor of these materials and the contracted providers (and any subcontractors, including providers or agents) who display the materials in their offices.

CMS Guidelines

Providers contracted with Medicare Advantage (and their contractors) are permitted to:

- Provide the names of Medicare Advantage sponsors with which they contract and/or participate to beneficiaries.
- Provide information and assistance in applying for the Low Income Subsidy (LIS).
- Make available and/or distribute plan marketing materials for a subset of contracted plans only as long as providers offer the option of making available and/or distributing marketing materials to all plans with which they participate. CMS does not expect providers to proactively contact all participating plans to solicit the distribution of their marketing materials: rather, if providers agree to make available and/or distribute plan marketing materials for some of their contracted plans, providers should do so knowing they must accept future requests from other plans with which they participate.

To that end, providers are permitted to:

- Provide objective information on Medicare Advantage sponsors' specific plan formularies, based on a particular patient's medications and health care needs.
- Provide objective information regarding Medicare Advantage sponsors', including information such as covered benefits, cost sharing and utilization management tools.
- Make available and/or distribute plan marketing materials including Prescription drug plan (PDP) enrollment applications, but not Medicare Advantage (MA) or Medicare Advantage-Prescription Drug (MA-PD enrollment applications for all plans with which the provider participates.
- To avoid an impression of steering, providers should not deliver materials/applications within an exam room setting.
- Refer their patients to other sources of information, such as State Health Insurance Plan SHIPs, plan marketing representatives, their state Medicaid Office, local Social Security Office, CMS' website at **http://www.medicare.gov** or **1-800-MEDICARE (1-800-633-4277**).
- Print out and share information with patients from CMS' website.
- **Providers are permitted to make available and/or distribute plan marketing materials for a subset of contracted plans only as long as providers offer the option of making available and/or distributing marketing materials to all.**

The *Medicare & You Handbook* or Medicare Options Compare (from **http://www.medicare.gov**), may be distributed by providers without additional approvals. There may be other documents that provide comparative and descriptive material about plans, of a broad nature, that are written by CMS or have been

previously approved by CMS. These materials may be distributed by Medicare Advantage sponsors and providers without further CMS approval. This includes CMS Medicare Prescription Drug Plan Finder information via a computer terminal for access by beneficiaries. Medicare Advantage sponsors should advise contracted providers of the provision, based on a particular patient's medications and health care needs.

2.17 Delegation

Delegated Activities

If Anthem has delegated activities to the provider, then Anthem will provide the following information to the provider and the provider shall provide such information to any of its subcontracted entities:

- A list of delegated activities and reporting responsibilities;
- Arrangements for the revocation of delegated activities;
- Notification that the performance of the contracted and subcontracted entities will be monitored by the plan
- Notification that the credentialing process must be approved and monitored by the plan; and
- Notification that all contracted and subcontracted entities must comply with all applicable Medicare laws, regulations and CMS instructions.

Delegation of Provider Selection

In addition to the responsibilities as set forth above, to the extent that the plan has delegated selection of the providers, contractors, or subcontractor to the provider, the plan retains the right to approve, suspend, or terminate any such arrangement.

2.18 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, or email. 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 redisclose 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.

3 SUMMARY OF PROVIDER CREDENTIALING PROGRAM

Anthem Discretion
The credentialing summary, criteria, standards, and requirements set forth herein are not intended to limit Anthem 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.

3.1 Credentialing Scope

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

- Medical doctors
- Doctors of osteopathic medicine
- Doctors of podiatry
- Chiropractors
- Optometrists providing health services covered under the health benefits plan
- Doctors of dentistry providing health services covered under the health benefits plan including oral 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 telemedicine practitioners who provide treatment services under the health benefits plan
- Medical therapists (for example, physical therapists, speech therapists, and occupational therapists)
- Genetic counselors
- Audiologists
- Acupuncturists (nonmedical doctors or doctors of osteopathic medicine)
- 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 company'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 an inpatient, residential or ambulatory setting, including:
    - Adult family care/foster care homes
    - Ambulatory detox
    - Community mental health centers (CMHC)
    - Crisis stabilization units
    - Intensive family intervention services
    - Intensive outpatient – mental health and/or substance abuse
    - Methadone maintenance clinics
    - Outpatient mental health clinics
    - Outpatient substance abuse clinics
    - Partial hospitalization – mental health and/or substance abuse
    - Residential treatment centers (RTC) – psychiatric and/or substance abuse
- Birthing centers
- Home infusion therapy agencies

The following Health Delivery Organizations are not subject to professional conduct and competence review under the Anthem 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 (a CMS-issued CLIA certificate or a hospital based exemption from CLIA)
- End stage renal disease (ESRD) service providers (dialysis facilities)
- Portable X-ray suppliers
- Home infusion therapy when associated with another currently credentialed HDO
- Hospice
- Federally qualified health centers (FQHC)
- Rural health clinics

3.2 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 the Anthem Credentials Committee ("CC").

The CC will meet at least once every 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 (for example, 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 (for example, 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/recredentialing 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 highly confidential. Access to information will be restricted to those individuals who are deemed necessary to attain the objectives of the company's credentialing program. In particular, information supplied by the Practitioner or HDO in the application, as well as other non-publicly available information will remain 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 30 calendar days of the identification of the issue. This communication will specifically 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 specific process for submission of this additional information, including where it should be sent. Depending on the nature of the issue in question, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue(s) in question, including copies of the correspondence or a detailed record of phone calls, will be clearly documented in the practitioner's credentials file. The practitioner or HDO will be given no less than 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.

3.3 Nondiscrimination Policy

Anthem will not discriminate against any applicant for participation in its programs or provider network(s) on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, the company 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 recredentialing 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 in the selection of practitioners. Should discriminatory practices be identified through audit or through other means, the company will take appropriate action(s) to track and eliminate those practices.

3.4 Initial Credentialing

Each practitioner or HDO must complete a standard application, deemed acceptable by Anthem, when applying for initial participation in one or more of the Anthem networks or plan programs. For practitioners, the Council for Affordable Quality Healthcare (CAQH) ProView® system is utilized. To learn more about CAQH, visit their web site at **www.CAQH.org**.

Anthem will verify those elements related to an applicants' legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the 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 verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

A. Practitioners

Verification Element
License to practice in the state(s) in which the practitioner will be treating covered individuals.
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 • The DEA/CDS registration must be valid in the state(s) in which practitioner will be treating covered individuals. Practitioners who see covered individuals in more than one state must have a DEA/CDS registration for each state.
Malpractice insurance
Malpractice claims history
Board certification or highest level of medical training or education
Work history
State or Federal license sanctions or limitations
Medicare, Medicaid or FEHBP sanctions
National Practitioner Data Bank report
State Medicaid Exclusion Listing, if applicable

B. HDOs

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

3.5 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 recredentialed every three (3) years unless otherwise required by contract or state regulations.

3.6 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 occur every three 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.

3.7 Ongoing Sanction Monitoring

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

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

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

3.8 Appeals Process

Anthem has established policies for monitoring and recredentialing practitioners and HDOs who seek continued participation in one or more of the Anthem 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 the Anthem 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 the Anthem 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 the Anthem determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to covered individuals. 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.

3.9 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:

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

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

A. For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine (ABPM), or American Board of Oral and Maxillofacial Surgery (ABOMS) in the clinical discipline for which they are applying.

B. If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.

C. If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.

D. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.

    1. As alternatives, MDs, DOs, DPMs and Oral Surgeons 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, ABPM, ABFAS, 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 the Anthem network AND the applicant's professional activities are spent at that institution at least 50% of the time.

2. Practitioners meeting one of these three 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 HFAP accredited hospital, or a network hospital. 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

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 180 calendar days of the date of submission to the CC for a vote;
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies;
4. No evidence of potential material omission(s) on application;
5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to covered individuals;
6. No current license action;
7. No history of licensing board action in any state;
8. No current federal sanction and no history of federal sanctions (per 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 covered individuals. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating covered individuals. Practitioners who treat covered individuals in more than one state must have a valid DEA/CDS 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 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 members will be notified of the need to obtain the additional DEA, unless the practitioner is delivering services in a telemedicine environment only and does not require a DEA or CDS registration in the additional location(s) where such telemedicine services may be rendered under federal or state law. If the applicant has applied for an additional DEA registration the credentialing process may proceed if all the following criteria are met:
    (a) It can be verified that the applicant's application is pending; and
    (b) The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
    (c) The applicant agrees to notify Anthem upon receipt of the required DEA registration; and
    (d) Anthem will verify the appropriate DEA/CDS registration via standard sources; and
    (e) The applicant agrees that failure to provide the appropriate DEA registration within a 90 day timeframe will result in termination from the network.
iii. Office-based practitioners who voluntarily choose to have a DEA/CDS registration that does not include all Controlled Substance Schedules (for example, Schedule, II, III or IV), if that practitioner certifies the following:
    (a) controlled substances from these Schedules are not prescribed within his/her scope of practice; and
    (b) he/she must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances from these Schedules should it be clinically appropriate; and
    (c) DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than those aforementioned.

10. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions;
11. No history of or current use of illegal drugs or history of or current alcoholism;
12. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
13. No gap in work history greater than six months in the past five years with the exception of those gaps related to parental leave or immigration where 12 month gaps will be acceptable.
14. 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.
15. A minimum of the past 10 years of malpractice case history is reviewed.
16. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in the Anthem network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;
17. No involuntary terminations from an HMO or PPO;

18. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
- Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
- Voluntary surrender of state license related to relocation or nonuse of said license;
    a. A NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria.
    b. 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);
    c. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five year post residency training window;
    d. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    e. 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.

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

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). Program must have been accredited within three (3) years of the time the practitioner graduated; full accreditation is required, and candidacy programs will not be considered.
b. Full accreditation is required, candidacy programs will not be considered.
c. If master's level degree does not meet criteria and practitioner obtained PhD training as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. To meet the criteria, the doctoral program must be accredited by the 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.

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 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.

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 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 covered individuals.

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 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.

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 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 years' experience practicing neuropsychology at least 10 hours per week.

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 (for example, 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.
        1. 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.
        2. Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
        3. 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.

    i. Process, requirements and Verification – Nurse Practitioners:
        1. 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.
        2. 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.

3. 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.
4. 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 company 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.
5. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
    a. Certification program of the American Nurse Credentialing Center (**www.nursecredentialing.org**), a subsidiary of the American Nursing Association (**http://www.nursingcertification.org/exam_programs.htm**); or
    b. American Academy of Nurse Practitioners – Certification Program (**www.aanpcertification.org**); or
    c. National Certification Corporation (**http://www.nccwebsite.org**); or
    d. 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
    e. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY (**http://oncc.org**);
    f. 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 the company is not required. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.
6. 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.
7. The NP applicant will undergo the standard credentialing processes outlined in company 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, recredentialing every three years, and continuous sanction and performance monitoring upon participation in the network.

8. Upon completion of the credentialing process, the NP may be listed in the company 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.
9. NPs will be clearly identified as such:
    a. On the credentialing file;
    b. At presentation to the Credentialing Committee; and
    c. On notification to Network Services and to the provider database.

ii. Process, Requirements and Verifications – Certified Nurse Midwives:

1. 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.
2. 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.
3. 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.
4. 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 company procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
5. All CNM applicants will be certified by either:
    a. The National Certification Corporation for Ob/Gyn and Neonatal Nursing; or
    b. The American Midwifery Certification Board, previously known as the American College of Nurse Midwifes.

   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 the company 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.

6. 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.
7. The CNM applicant will undergo the standard credentialing process outlined in company 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, recredentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
8. Upon completion of the credentialing process, the CNM may be listed in the company 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.
9. CNMs will be clearly identified as such:
    a. On the credentialing file;
    b. At presentation to the Credentialing Committee; and
    c. On notification to Network Services and to the provider database.

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

1. 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.
2. 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.
3. 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.
4. 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 company procedures. If there are in force adverse actions against

the DEA, the applicant will be notified and the applicant will be administratively denied.

5. 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 the company 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.
6. 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.
7. The PA applicant will undergo the standard credentialing process outlined in company 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, recredentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
8. Upon completion of the credentialing process, the PA may be listed in the company 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.
9. PA's will be clearly identified such:
    a. On the credentialing file;
    b. At presentation to the Credentialing Committee; and
    c. On notification to Network Services and to the provider database.

D. Currently Participating Applicants (Recredentialing)

1. Submission of complete recredentialing application and required attachments that must not contain intentional misrepresentations or omissions;
2. Recredentialing application signed date within 180 calendar days of the date of submission to the CC for a vote;
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs, Medicare, Medicaid or FEHBP. If, once a Practitioner participates in the Anthem 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 the other Anthem credentialed provider network(s).
4. Current, valid, unrestricted, unencumbered, un-probated license to practice in each state in which the practitioner provides care to covered individuals;
5. No new history of licensing board reprimand since prior credentialing review;
6. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
7. Current DEA/CDS registration and/or state controlled substance certification without new

(since prior credentialing review) history of or current restrictions;

8. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; OR for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a network practitioner of similar specialty at a network HDO who provides inpatient care to covered individuals needing hospitalization;
9. No new (since previous credentialing review) history of or current use of illegal drugs or alcoholism;
10. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
11. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
12. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
13. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
14. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
    a. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    b. Voluntary surrender of state license related to relocation or nonuse of said license;
    c. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    d. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    e. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five year post residency training window;
    f. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    g. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.
15. No QI data or other performance data including complaints above the set threshold.
16. Recredentialed at least every three 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 Covered Individual access need only when the CC review indicates compliance with Anthem standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are recredentialed at least every three years to assess the HDO's continued compliance with Anthem standards.

A. General Criteria for HDOs:

1. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to covered individuals. The license must be in good standing with no sanctions.
2. Valid and current Medicare certification.
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the FEHBP. Note: If, once an HDO participates in the Anthem 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 the other anthem 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 the Anthem quality and certification criteria standards have been met.

B. Additional Participation Criteria for HDO by Provider Type:

3.10 HDO Type and Anthem Approved Accrediting Agent(s)

Medical Facilities

Facility type (medical care)	**Acceptable accrediting agencies**
Acute care hospital	CIQH, CTEAM, HFAP, DNV/NIAHO, TJC
Ambulatory surgical centers	AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC
Birthing center	AAAHC, CABC, TJC
Clinical laboratories	CLIA, COLA
Dialysis center	TJC, CMS Certification
Home health care agencies (HHA)	ACHC, CHAP, CTEAM , DNV/NIAHO, TJC
Home infusion therapy (HIT)	ACHC, CHAP, CTEAM, HQAA, TJC
Portable X-ray suppliers	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, TJC, HFAP
Adult family care homes (AFCH)	ACHC, TJC
Adult foster care	ACHC, TJC
Community mental health centers (CMHC)	AAAHC, TJC, CHAP, CARF, COA
Crisis stabilization unit	TJC
Intensive family intervention services	CARF
Intensive outpatient — mental health and/or substance abuse	ACHC, DNV/NIAHO, TJC, COA, CARF

Outpatient mental health clinic	HFAP, TJC, CARF, COA, CHAP
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	DNV/NIAHO, TJC, HFAP, CARF, COA

Rehabilitation

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute inpatient hospital – detoxification only facilities	DNV/NIAHO, HFAP, TJC, CTEAM
Behavioral health ambulatory detox	CARF, TJC
Methadone maintenance clinic	CARF, TJC, COA
Outpatient substance abuse clinics	CARF, TJC

3.11 Utilization Management Medicare Advantage Plans

Components of utilization management for Anthem Medicare Advantage plans:

- Application of Clinical Criteria Guidelines
- Referral management
- Referring out-of-network
- Providing *Advanced Beneficiary Notice of Noncoverage* (*ABN*)
- Precertification
- Concurrent review
- Denials
- Emergency care/urgent care
- Case management
- Under and over utilization

Application of Clinical Criteria Guidelines

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

Anthem uses the following utilization management criteria for their MA plans:

- **Medicare Coverage Directives** are the primary criteria used in making decisions regarding coverage for the Anthem Medicare Advantage plans. Medicare Advantage plans are required to provide their Medicare enrollees those services that are covered under Medicare and available to other fee-for-service Medicare beneficiaries residing in the geographic area covered by the plan. This means that coverage determinations for our members must be in accordance with CMS national coverage decisions, as well as local coverage determinations by Medicare intermediaries and carriers.
- **Anthem Medical Policy** is developed to assist in interpreting contract benefits. Medical policy includes technology assessment and medical requirements for coverage of selected technologies and services. These guidelines are available upon request.
- **Medically Necessary (or Medical Necessity)** means services, treatments, diagnostic procedures, or supplies provided to members that are medically required and appropriate to diagnose and/or treat a

member's physical or mental condition. Also, such services, treatments, diagnostic procedures, or supplies must: 1) meet widely accepted evidence-based criteria and professionally recognized standards of health care; 2) not be used primarily for the comfort or convenience of the member, the member's family or caregiver, or the member's treating physician; 3) not be excessive in cost as compared to alternative services or supplies effective for the diagnosis and/or treatment of the member's physical or mental condition; and 4) not be provided to the member as an inpatient when the services or supplies could be safely and appropriately provided to the member in an outpatient setting.

Guidelines are also developed for disease management and preventive services. These guidelines are available upon request or at **https://www.anthem.com/medicareprovider** within the MA Product pages under *Additional Information.*

- CMS National and Local Coverage Determinations or other Medicare guidance, (for example, *Medicare Policy Benefit Manual*, *Medicare Managed Care Manual*, *Medicare Claims Processing Manual*, Medicare Learning Network.

3.12 Use of Clinical Guidelines

Application of criteria must be reviewed in the context of the individual member and consider age, co-morbidities, extenuating circumstances and/or complications, response to treatment, psychosocial issues, support network, and home environment. In the application of decision criteria for specific consumers, relevant characteristics of the local delivery system are considered, including, but not limited to, the availability of certain types of facilities or services within the service area and the capability of facilities or other providers to offer needed services.

The hierarchy for UM criteria application will be applied to all medical necessity determinations for coverage for services provided to members eligible for benefits under Medicare Advantage products. CMS national and local coverage guidelines are referenced first for all medical necessity reviews.

If there is no guidance or criteria available in CMS, the Anthem Corporate Medical Policies followed by evidence-based guidelines, such as MCG Guidelines criteria, Compendia, NCCN (*National Comprehensive Cancer Network Clinical Practice Guidelines*) may be used.

Anthem Corporate Medical Policy

Anthem decision criteria incorporate nationally recognized standards of care and practice, current professional literature, and cumulative professional expertise and experience. The decision criteria used by senior business clinical reviewers are evidence based and consensus-driven. Criteria are updated as standards of practice or technology change. Actively practicing physicians and other relevant practitioners are involved in the development and adoption of the review criteria. An annual review and approval is performed by the Medical Policy and Technology Assessment Committee (MPTAC) or when applicable for certain specialty areas, another national clinical committee that utilizes comparable procedures for development of decision criteria. The criteria are reviewed annually for approval and adoption by the Anthem-affiliated companies.

3.13 Referral Management

For the Anthem Medicare Advantage plans, members are required to select a PCP who serves as the coordinator of care to ensure access to appropriate medically necessary specialty care. When referring a member to a specialist, selecting a participating provider within our Medicare network will maximize the members benefit and minimize their out-of-pocket expenses. If you need help finding a participating

provider, please call Provider Services or if you believe you must refer to a provider outside of our network, you must contact Anthem in advance of that request in order for an organization determination to be made. Failure to initiate this request may result in claims denials and member liability. This includes such services as laboratories; however, it does not include urgent, emergent or out-of-area renal dialysis services.

3.14 Self-Referral Guidelines

Medicare members may self-refer for the following services:

- Screening mammograms
- Behavioral health
- Influenza and pneumococcal vaccinations
- All preventive services (for example, routine physical examinations, prostate screening and preventive women's health services, such as Pap tests)
- Disease Management Centralized Care Unit services

Anthem Medicare Advantage HMO members must obtain all routine services within the Anthem provider network, unless urgent, emergent, out-of-area renal dialysis or when prior approval has been provided by the plan. Anthem Medicare Advantage HMO-POS members have limited out of network coverage for routine services. All services not covered under the Point of Service (POS) benefit must be obtained within the Anthem provider network, unless urgent, emergent, out-of-area renal dialysis or when prior approval has been provided by the plan.

Anthem Medicare Advantage PPO members can utilize providers both in and out of the network.

- Out-of-network referrals do not require plan notification or authorization however can be requested and is encouraged for some services to ensure there is no delay in claims processing as out-of-network services are subject to a medical necessity review upon claims submission, if not precertified. Services deemed to be noncovered will result in the claim denying with member liability unless urgent, emergent, out-of-area renal dialysis or when prior approval has been provided by the plan.
- Out-of-network services are subject to the member's out-of-network cost share. Anthem Medicare Advantage PPO members also will have less out-of-pocket expense if they select a provider in the network.

3.15 Referral Guidelines

PCPs may only refer members to Anthem Medicare contracted network specialists to ensure the specialist receives appropriate clinical background data and is aware of the member's ongoing primary care relationship. If a member does not have out-of-network benefits, has expressed a desire to receive care from a different specialist or you believe the required specialty is not available within the contracted network, contact Anthem directly for precertification. Referring a Medicare member out-of-network who does not have the benefit will result in the claim denying with member liability unless urgent, emergent, out-of-area renal dialysis or if prior authorization was received by the plan. Contact Anthem directly for precertification. Although not required, precertification is encouraged for PPO members who want to receive notification of advanced coverage when utilizing an out-of-network provider for services generally precertified.

3.16 Providing Noncovered Services Advanced Notification

For services that require prior authorization or are noncovered by the plan (in other words statutory exclusion), it becomes extremely important that Anthem authorization procedures are followed. If a member elects to receive such care, the member cannot be held financially responsible unless notified in advance of the noncovered services. In such cases when the network physician fails to follow Anthem authorization protocols, Anthem may decline to pay the claim in which case the physicians will be held financially responsible for services received by the member. Again, CMS prohibits holding the member financially responsible in these cases.

CMS issued guidance concerning the Advanced Beneficiary Notice of Noncoverage (ABN). The ABN is a Fee-for-Service document and cannot be used for Medicare Advantage denials or notifications. Per the ***CMS Medicare Claims Processing Manual*** (page 4), the ABN is given to beneficiaries enrolled in the Medicare Fee-For-Service program. It is not used for items or services provided under the Medicare Advantage (MA) Program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D). CMS advised Medicare Advantage plans that contracted providers are required to provide a coverage determination for services that are not covered by the member's Medicare Advantage plan. This will ensure that the member will receive a denial of payment and accompanying appeal rights. If you have any doubt about whether a service is not covered, please seek a coverage determination from the plan.

3.17 Access to Care and Services

Anthem may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in a Medicare Advantage (MA) plan offered by an organization on the basis of any factor that is related to health status. This includes but is not limited to the following: medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability and disability, except as it relates to end-stage renal disease. The Anthem MA Plans must meet the requirement to provide coverage and payment for all services that are covered under Part A and Part B of Medicare. The Medicare Advantage organization must ensure that all covered services, including additional or supplemental services contracted for by the Medicare enrollee, are accessible under the plan. Medically necessary services must be available 24/7.

Anthem has established performance measures to assist in developing and maintaining adequate providers and practitioners in all our Medicare Advantage networks. Performance is monitored at least annually and strategies are developed as needed to overcome deficiencies in the networks. Other pertinent sources of information for reviewing network adequacy include appeals and complaints regarding access and availability. Out-of-network referrals are approved for Anthem HMO members when providers and practitioners are not available or accessible in the members' geographic locations. There are also instances where an in-network provider is not available for members in our Local and Regional PPO's. In those instances, the in-network provider should collaborate with our utilization management area to obtain authorization for out of network services. In certain circumstances, the member may only be responsible for the in-network cost sharing.

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

Appointment access standards for primary care services are:

Service	Access Requirement
Emergency	Immediate 24 hours a day/seven days a week access available — for emergent diagnoses. Behavioral health providers must be available to assess a patient experiencing an emergent situation within 6 hours.
Urgent	Within 48 hours — including behavioral health urgent services.
Routine	Within 10 business days — including behavioral health routine services.

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

The Anthem medical management department will coordinate authorizations for members affected by a provider termination when they are undergoing treatment for specific conditions. Members not undergoing treatment at the time of a provider termination will be referred to their PCP for a referral to another participating provider of that like specialty.
Plans may select the providers through whom services are provided as long as:

- The plan makes services available and accessible within the service area with reasonable promptness and in a manner, which assures continuity.
- The plan provides access to appropriate providers, including credentialed specialists, for medically necessary care; and if a network provider is unavailable or inaccessible then the MA organization must arrange for services outside of the network.
- Coverage is provided for emergency services without regard to prior authorization or whether the provider was a participating provider.
- The plan maintains and monitors a network of appropriate providers.
- The plan gives women enrollees direct access to women's health specialists within the network for women's routine and preventive health care services.
- The plan establishes written standards for timeliness of access to care and customer service that meet or exceed standards established by CMS and continuously monitors to assure continuous compliance with standards.
- The plan ensures services are provided in a culturally competent manner.
- The plan ensures services are available 24/7 when medically necessary.
- The MA organization ensures continuity of care and integration of services and makes a "best effort" attempt to conduct an initial assessment of an enrollee's health care needs within 90 days of enrollment.

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

3.18 Direct Access to Preventive/Routine Gynecological and Mammography Services

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

or mammography services provided by a network provider for the Medicare HMO. Members in the Medicare Advantage PPO may choose either a network or a nonnetwork provider. Please refer to the most recent Medicare Advantage provider directory for the Mammography Center and OB/GYN specialty provider listings. Our provider directories are also available online at **www.anthem.com/medicareprovider**.

3.19 Direct Access to Influenza and Pneumococcal Immunizations with no Cost Sharing

Anthem strongly encourages all members to receive influenza and pneumococcal immunizations. No referral or copay for the immunization is required.

3.20 Prior Authorization

Anthem must be notified of all inpatient admissions, including hospital, skilled nursing facility, long-term acute care hospital or acute rehabilitation center within one business day of admission. For services including but not limited to: selected diagnostic, outpatient and inpatient procedures, precertification must be requested at a minimum of 72 hours in advance. UM associates will be requesting relevant clinical information, including signs, symptoms, treatment plans, diagnostic test results, medical records and attempts at conservative treatment (when appropriate) in order to complete the precertification process.

Providers are required to provide notification in advance of services to allow Anthem to meet CMS processing timeframes:

Medical:

- Standard — 14 calendar days
- Expedited — 72 hours
- Pharmacy (Including Part B Medical injectables)
- Standard — 72 hours
- Expedited — 24 hours
- ER admissions — Anthem requires notification within one business day for all ER admissions.

CMS defines an expedited/urgent request as ‘an expedited/urgent request for a determination is a request in which waiting for a decision under the standard time frame could place the member's life, health or ability to regain maximum function in seriously jeopardy.’ Contracted providers should submit requests in accordance with CMS guidelines to allow for organization determinations within the standard turnaround time, unless the member urgently needs care based on the CMS definition of an expedited/urgent request.

3.21 Interactive Care Reviewer (ICR)

- Currently for use in CA, CO, CT, FL, GA, IN, KY, ME, MO, NH, NJ, NM, NY, OH, TN, TX, VA, WA, and WI.

The Anthem ICR is the preferred method for the submission of preauthorization requests offering a streamlined and efficient experience for providers requesting inpatient and outpatient medical. 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 preauthorization requests online, eliminating the need to fax. ICR allows detailed text, photo images and attachments to be submitted along with your request.
- Make inquiries on previously submitted requests via phone, fax, ICR or other online tool.
- Instant accessibility from almost anywhere including after business hours.
- Use the dashboard to provide a complete view of all UM requests with real-time status updates including email notifications if requested using a valid email address.
- Real-time results for some common procedures with immediate decisions.
- Access ICR under *Authorizations and Referrals* via the Availity Portal (**https://www.availity.com**).

To register for an ICR webinar use the attached link: **https://bit.ly/2z394yL**.

For an optimal experience with the Anthem ICR, use a browser that supports 128-bit encryption. This includes Internet Explorer, Chrome, Firefox or Safari. The Anthem ICR is not currently available for the following:

- Transplant services.
- Services administered by vendors such as AIM Specialty Health®. (For these requests, follow the same prior authorization process you use today.)

Our website will be updated as additional functionality and lines of business are added throughout the year.

An Anthem Medical Management Nurse will review each request for admission, procedures or services. If evidence-based criteria are met, the review nurse will document clinical data and authorize the requested service. Approval letters are mailed to the member, the PCP, the hospital and the attending physician within one business day of the decision. If the review nurse determines that the criteria are not met, or there is insufficient information to complete a review, the request for service is referred to a medical director for review. Only physicians are able to render medical necessity denials. If a denial decision is indicated, the notification includes information regarding the appeal process, availability of a physician to discuss the case, and the reason for the denial including the specific clinical criteria or benefits provision.

Appropriately licensed and trained professionals make UM decisions according to established criteria. Nonclinical associates, under the supervision of a licensed professional, may collect nonclinical data and may approve cases that do not require clinical review. Board-certified practitioners are utilized in making decisions of medical necessity. Again, only physicians are able to render denials. Practitioners from appropriate specialty areas are used as needed for medical necessity reviews and appeals.

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

3.22 How to request a Prior Authorization

Failure to request a prior authorization for an admission or provide notice of emergent inpatient admission will result in administrative denial. This policy has been in effect since May 1, 2015. Notify Anthem as soon as possible for planned or unplanned inpatient admissions, but no later than within one business day of admission.

If the required precertification is not obtained within the specified time frame, the claim will be administratively denied due to failure to notify Anthem of the admission. The provider will not receive payment for the service. Providers cannot bill the member for these denied services.

If you do not notify us within the required time frame, you may file a plea indicating the reason for the failure to provide timely notification as per above. **Appeals for failure to provide timely notification will not be reviewed clinically until the late notification denial is resolved.** When submitting a response to a denial for failure to notify, the reason for the failure to provide proper notification should be presented. If your justification is accepted, the case will be sent for initial review and any adverse determination for medical necessity will be provided with subsequent appeal rights. Note, Anthem will not request information to justify the reason for late or no notification, nor if the notification requirement is waived will Anthem request medical records for any subsequent review.

To obtain authorization or to verify member eligibility, benefits and account information, please call the telephone number listed on the back of the member's identification card.

Prior Authorizations, Observation and Timely Notification Reminders for Medicare Advantage Members
Getting the best care in the most appropriate setting is key to achieving the best outcomes for our Medicare Advantage members. These members rely on their health care professionals and their health plan to help coordinate this important aspect of their care. To do this, timely requests for service and communication is essential.

Please be aware of the following considerations and requirements to help ensure effective coordination of care for Medicare Advantage members and assure consistent application of the Centers for Medicare and Medicaid Services guidelines and /or nationally recognized evidence based medical necessity guidelines) for pre- and post-service medical necessity and site of service reviews.

Inpatient Acute Medical Admissions
Hospitals are required to notify and/or obtain a prior authorization as early as possible, but no later than within one business day of admission. The process for decision making is fastest when all supporting documentation accompanies the request for authorization of services.

Planned Inpatient Admissions
Prior authorization is required for **all** planned inpatient admissions. The request for prior authorization for a planned inpatient stay should occur as soon as the provider determines the need for the inpatient admission. Providers should submit prior authorization requests in advance of the inpatient admission to allow for CMS processing timeframes. CMS standard processing timeframe is 14 calendar days, expedited processing timeframe is 72 hours. Services may not be reimbursable if the precertification is not obtained.

Hospital observation, in-patient admission and timely notification
Please notify us as soon as possible following admission but no later than within one business day of admission.

If we don't receive notification of admission, a retrospective review for medical necessity and site of service per the above hierarchy of review, will be conducted when the claim is submitted.

3.23 Inpatient Acute Concurrent Review
Anthem performs concurrent review for Medicare Advantage members at contracted in-area hospitals. The review's purpose is to continuously improve medical care by:

- Determining the need for continued stay

- Initiating discharge planning and case management.

3.24 Skilled Nursing Facility

Precertification for admission to skilled nursing facilities

According to CMS guidelines, patients should be admitted to a skilled nursing facility when "… as a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF.*

Skilled nursing, acute rehabilitation and long-term care facilities are required to obtain precertification for Medicare Advantage members before that member can be admitted. For the member to receive maximum benefits, the health plan must authorize or precertify the admission. To assure payment according to contract, before a Medicare Advantage member is transferred to the receiving facility, the facility must notify the plan and receive a precertification authorization for that transfer.

Please note:

- Precertification includes a review of both the service and the setting.
- Please present the request for admission to a skilled nursing facility, acute rehabilitation facility, and/or long-term acute care facility prior to admission.
- Please provide all supporting documentation with the request for precertification at the time of the request for admission.
- If the required precertification is not obtained prior to the service, the claim may be administratively denied for all days accrued prior to receiving an approval for admission, in accordance with your provider contract.
- To obtain precertification or to verify member eligibility, benefits and account information, please call the telephone number listed on the back of the member's identification card.

Please refer to your provider agreement, this provider manual, and the Medicare Advantage *Precertification Guidelines* found at the Medical Policy, UM Guidelines and Precertification Requirements link on the Anthem provider home page at **www.anthem.com/medicareprovider** for further information on precertification and precertification requirements.

To obtain authorization or to verify member eligibility, benefits and account information, please call the telephone number listed on the back of the member's identification card.

Please share this information with clinical staff and others involved with facility authorization and admissions.

We look forward to working with you and your colleagues to ensure our members are discharged at the right time clinically, to the right place and achieve the best clinical outcome.

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

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

- The patient requires skilled nursing services or skilled rehabilitation services, in other words, services that must be performed by or under the supervision of professional or technical personnel.
- The patient requires these skilled services on a daily basis.

- The skilled services can be provided only on an inpatient basis in a SNF.

If any one of these three factors is not met, a stay in a SNF, even though it might include the delivery of some skilled services, may not be covered. If a stay in a SNF is not covered, Medicare Part B services may still be obtained and members will be assessed the applicable copays. A benefit period is used to determine coverage under the Anthem Medicare Advantage plans in the same manner as Original Medicare. A benefit period starts with the first day of a Medicare covered inpatient hospital or SNF stay and ends when the member has been out of the hospital or SNF for 60 consecutive days.

* *Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance (Rev. 155, 04-20-12)*

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

The obligation on the provider to follow coverage limits for Original Medicare benefits (as provided in 42 CFR 422.100) must be met whenever a provider furnishes Original Medicare, SNF and inpatient hospital services to enrollees of Medicare Advantage organizations. This obligation applies to all SNFs and applies to both teaching and nonteaching hospitals. This obligation can be implemented by providers submitting to Medicare Administrative Contractors (MACs) no-pay claims (with condition code, 04). It is also the provider's obligation to keep an audit trail on these claims.

3.25 Home Health Services

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

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

3.26 Denials

Denials for emergent inpatient admissions, discontinuation of coverage, and lack of information may not be issued to Anthem Medicare Advantage (MA) members. CMS does not recognize denials due to a lack of information. Therefore, when there is not enough information to certify or deny a requested

service requiring utilization management review, further attempts must be made to collect the missing information.

Based on the application of our clinical criteria guidelines, if the admission or continued inpatient stay does not meet medical necessity criteria, it is referred to the medical director or physician consultant for medical necessity determination. Physician review decisions are made within one working day. Plan providers are also entitled to a physician-to-physician review. Hospitals must notify Medicare Beneficiaries who are hospital inpatients about their discharge appeal rights by complying with the requirement for providing the Important Message from Medicare (IM), including the time frames for delivery. For a copy of the notice and additional information regarding this requirement, go to: **http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp.**

Notice of Medicare Noncoverage Requirements
CMS requires 100% compliance of providers to deliver a *Notice of Medicare Non-Coverage* (*NOMNC*) to every Medicare beneficiary at least two days prior to the end of their skilled nursing, home health or comprehensive outpatient rehabilitation facility (CORF) care. Additionally, CMS requires Medicare inpatients to receive written information about their discharge rights. CMS has defined how this "Important Message from Medicare" (IM) is to be delivered by facilities to Medicare beneficiaries.

Anthem has established policies and procedures that require skilled nursing facilities to comply with CMS mandatory requirement for all Medicare beneficiaries enrolled in Medicare Advantage Plans to receive a valid *Notice of Medicare Non-Coverage* (*NOMNC*), in a timely manner at the termination of skilled care at a skilled nursing facility (SNF), to allow the member the opportunity to appeal to the Quality Improvement Organization (QIO), in the event they disagree with the termination of services.

Anthem responsibility and liability
When Anthem has approved coverage of a member's admission to a SNF, Anthem ensures that the member receives the verbal notification with appeal information and a valid *NOMNC* is sent to the SNF for the member to receive the *NOMNC* at least two calendar days in advance of the services ending, even if the member agrees with services ending, in compliance with CMS regulation.

Anthem is extending the notice period up to 8 p.m. (in the time zone the facility is located), with the next two calendar days following the date of the denial notice to be considered the required two-day notice.

Below is an outline of determining the last approved day after the decision has been rendered to end services:

If denial notice (*NOMNC*) issued with confirmation of verbal notification and appeal information provided to the member, on the below day and time in the time zone the facility is located	Then last approved day (LAD) will be on	Members' discharge will occur or member financial responsibility will begin on
Monday (12 a.m. to 8 p.m.)	Wednesday	Thursday
Tuesday (12 a.m.to 8 p.m.)	Thursday	Friday
Wednesday (12 a.m. to 8 p.m.)	Friday	Saturday
Thursday (12 a.m. to 8 p.m.)	Saturday	Sunday
Friday (12 a.m. to 8 p.m.)	Sunday	Monday
Saturday (12 a.m. to 8 p.m.)	Monday	Tuesday

Sunday (12 a.m.to 8 p.m.)	Tuesday	Wednesday

The Anthem verbal notification to the member and/or verbal or fax receipt confirmation of the delivery of the *NOMNC* submitted prior to 8:01 p.m. (in the time zone the facility is located), will be considered a valid delivery date/time to the facility.

Anthem Contracted SNF Provider Responsibility and Liability
The SNF providers are responsible for delivering the *NOMNC* on behalf of Anthem, to the member or representative **and** for obtaining signature(s) the same day received by Anthem, but no later than two days before the member's covered services end. In the event the SNF is not able to deliver the *NOMNC* and obtain signature(s) the same day Anthem issues the *NOMNC*, the SNF provider is responsible for reissuing a *NOMNC* with the appropriate LAD to allow the member at least two calendar days in advance of the services ending.

In the event the member is in need of an authorized representative to acknowledge/sign the *NOMNC*, and the SNF is unable to deliver it to the authorized representative the same day Anthem issues it, the SNF should telephone the representative the same day the *NOMNC* is issued, to advise him/her when the beneficiary's services are no longer covered. The date of the conversation is the date of the receipt of the notice. The *NOMNC* must be mailed on the same day.

The SNF provider is also responsible to issue a *NOMNC* (created by the SNF provider) for members who services are expected to be fewer than two days duration or when a guaranteed discharge date is in place.

Liability will remain with the SNF in the event the acknowledgement of receipt and delivery of the *NOMNC* to the member or member's representative is not completed within the same day received. The authorization through the last approved day (LAD) will remain the same for the facility. The member may receive a new *NOMNC* with a new LAD to extend the covered services, with no liability to the member or Anthem, in order to allow the member the adequate days/time to appeal to the QIO, should the member disagree with the termination of services.

Anthem Medicare Advantage Member Responsibility and Liability
The member or representative is responsible for acknowledging receipt of the *NOMNC* by signing the document. The member or representative is also responsible for contacting the QIO (no later than noon of the first day after receiving the *NOMNC*), if he or she wishes to appeal the termination and obtain an expedited review. The member may also appeal to the Anthem Appeal Department should they miss their time frame for appealing to the QIO, if the member disagrees with the termination of services.

Liability for the member will begin the day following the last approved day as specified on the *NOMNC*, should the member choose not to appeal the termination of services.

Note: QIOs must be available both to receive and respond to an enrollee's appeal request at all times (CMS Chapter 13 section 90.2)

Refer to the Provider and Member liability section of the provider contract with Anthem for further details.

3.27 Preservice denials

When a contracted provider is denied a preservice request for a member, federal regulations CFR §422.568(c) and (d) grant an MA member the right to receive a *Notice of Denial of Medical Coverage* (*NDMC*) from the MA organization regarding his/her appeal rights. Therefore, a physician or practitioner

is required as a matter of routine to notify members about their right to receive such information. The notice to the member must provide, in addition to information about the right to receive detailed information, all information necessary to allow the member to contact the health plan. The Anthem Network Management department will provide the required notification language along with guidance on delivery methods acceptable to CMS.

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

The Anthem MA plans are financially responsible for emergency services provided by contracted and noncontracted providers where services are immediately required because of an emergency medical condition. The pan is also financially responsible for urgently needed services, post-stabilization care, and ambulance services, including ambulance services dispatched through 911 or its local equivalent, where other means of transportation would endanger the beneficiary's health.
A Medicare Advantage organization is required to cover emergency services for its MA members regardless of whether the services were preauthorized or the organization has a contractual agreement with the provider of the services. Therefore, emergency services for members are covered without regard to prior authorization or whether services were provided in or out of the service area.

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

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

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

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

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

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

1. A plan physician with privileges at the treating hospital assumes responsibility for the member's care.

- A plan physician assumes care through transfer.
- The MA organization's representative and the treating physician reach an agreement on the member's care.
- The member is discharged.

3.29 Case Management

Case management is a collaborative process that assesses, develops, implements, coordinates, monitors, and evaluates case management plans designed to optimize members' health care benefits while empowering the members to exercise the options and access the services appropriate to meet their individual health needs, using communication and available resources to promote quality and effective outcomes. Members who might benefit from case management are identified through a referral process. Case management referrals will be accepted from both internal and external sources.

- Internal sources include, but are not limited to, utilization management associates, customer service associates, account managers, appeals/grievance associates, and sales staff.
- External sources include, but are not limited to, hospital staff, discharge planners, social services, physicians and other health care providers, members or their families.
- Anthem discharge planners collaborate with all pertinent parties in the development of the discharge plan (in other words, PCP, specialist, Medical Director) to ensure the members needs are met before the member leaves the hospital setting. Anthem has designed a platform that provides a single point of contact to providers and facilities to ensure effective and collaborative discharge planning – of which streamlines the process for our providers while providing a more proactive, informative, and comprehensive transition for the member and their care partner to fully understand the care plan in other words, ensuring ancillary needs are met (DME received before member returns home, home infusion training is required, etc.). Additional intensified discharge planning efforts also include:
    - Performing medication reconciliation
    - Refer members to high-risk condition management programs, where applicable
    - Manage palliative care needs and refer to hospice when appropriate
    - Integrate psych and social workers where necessary

In addition, case referrals can be generated prospectively from the UM system during the precertification process and retrospectively from the claims system through claims data analysis and data review activities. Case referrals may also be triggered by the results of *Senior Health Risk Assessment* surveys and/or internal disease management registries, as appropriate. The *Senior Health Risk Assessment* is a risk appraisal, which evaluates health and wellness factors such as member's self-perception of health, presence of chronic or serious conditions, functional limitations, prior health care utilization and availability of social support. These factors are potentially predictive of future health care needs and we make a best-effort attempt to conduct this initial assessment of each enrollee's health benefit needs, including following up on unsuccessful attempts to contact the enrollee, within 90 days of the effective date of enrollment.
Essential functions of an Anthem case manager include the following:

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

Planning: The case manager develops a member centered case management plan. This plan is developed in conjunction with the physician and specifies goals that meet the benefit needs of the member in the best

way possible. This means identifying both short and long-term goals. It is essential that the case manager understand the benefits contained in the member's plan in order to formulate a case management plan.

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

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

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

3.30 Stars Outbound Call (OBC) Program

The Medicare Advantage Stars Outbound Call (OBC) Program plays a key role in addressing the Anthem approach for Medicare Advantage members in improving their healthy by getting the quality of care they need at the right time and in the right setting through conducting an outbound call to members and or providers to communicate the importance of obtaining preventive services such as colorectal screening, mammograms, annual wellness visits, and retinal eye exams.

By closing members gaps in care, this will help improve member health outcomes. Focused questioning by our Patient Education Coordinators (PEC), pharmacists, and technicians address key clinical measures to ensure our members receive the right care at the right time.

This program allows members to be proactively involved in their own care by notifying them of preventive screenings that can detect and help prevent chronic illness and highlighting the potential benefit of the proactive behavior. Focused scripting and call messaging allows for barrier assessment and provides actionable messaging aligned with behavior change. Members with barriers to care are offered assistance with transportation coordination, financial needs, or provided access to community resources within their respective area. Care coordination is offered along with referrals to a pharmacist, nurse, or social worker to address any issues or to receive assistance with scheduling recommended care.

3.31 Under and Over Utilization

Anthem has established measures to detect potential under and over utilization of services. Inpatient, outpatient, and ambulatory care utilization reports are monitored regularly against targets. Actions are implemented as needed.

Anthem does not compensate, reward or give incentives, financially or otherwise, to its employees, consultants, or agents for inappropriate restrictions of care. Utilization review decision making for the Anthem MA plans is based solely on appropriateness of care and service and in accordance with applicable Medicare coverage criteria and guidelines.

3.32 Readmission Review Process

Readmission

For all services reimbursed by a DRG Rate or Case Rate, a readmission within 30 days of the discharge of the first admission for a related diagnosis or procedure, a complication arising out of the first admission, a readmission for services that should have been rendered during the previous admission, or a premature discharge is considered part of the original admission for reimbursement.

The specific situations for which the readmission payment may be considered part of the original admission for reimbursement are:

- Member is discharged before all medical treatment is rendered. Care during the second admission should have occurred during the first admission.
- Member is discharged without discharge criteria being met, including the clinical and level of care criteria.
- Member is discharged from the hospital after surgery, but is readmitted within 30 days. The standards of care for evaluating the patient for known complications are not documented in the record. The readmission is due to a direct or related complication from the surgery.
- Member discharged from the hospital with a documented plan to readmit within 30 days for additional services (doctor requested, member requested).
- Member is discharged to allow resolution of a medical problem that, unless resolved, is a contraindication to the medically necessary care that will be provided during the second admission.
- Member is discharged meeting discharge criteria but nonclinical factors have not been addressed, and member has had previous 30-day admits. Member has issues or barriers that require discharge plans beyond the typical.

If a subsequent admission is reimbursed at a methodology other than a DRG or Case Rate (in other words, Per Diem Rate or %age Rate), then Anthem shall only reimburse the facility for the DRG or Case Rate of the original admission. None of these scenarios shall be combined to qualify for outlier reimbursement, if applicable If facility is an acute care hospital and is part of a hospital system operating under the same *Facility Agreement*, and/or if the facility shares the same tax identification number with one or more acute care hospitals, then a readmission during the same 30 day period to another acute care hospital within the system, and/or another acute care hospital operating under the same tax identification number as the facility, shall be subject to this readmission provision.

4 SPECIAL NEEDS PLAN (SNP) MEMBERS ONLY

4.1 Model of Care

We have a model of care program in place for members of our Special Needs Plans (SNPs). Our model of care program is comprised of the following elements:

1. Perform an evaluation of our population and create measurable goals designed to address the needs identified. The SNP model of care is designed to improve the care of our members in all of the following areas:
    - Improving access and affordability of the healthcare needs of the population
    - Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the health risk assessment (HRA), individualized care plan (ICP) and interdisciplinary care team (ICT).
    - Enhanced care transitions across all health care settings and providers
    - Ensuring appropriate utilization of services for preventive health and chronic conditions.
    - Goals specific to the population may be defined as part of our model of care.
2. Our staff structure and care management roles are designed to manage the special needs population. Each SNP member will have an assigned care coordinator, as well as an individualized interdisciplinary care team which may include any of the following members: nurses, physicians, social workers, pharmacists, our member, behavioral health specialists, or other participants as determined by the member.
3. We work to complete a telephonic HRA on each member. For new members the goal is to complete the initial HRA within 90 days of eligibility and annually before the anniversary of the last HRA. As some individuals may be difficult to reach by phone, our team may contact your office for updated contact information. Our assessment covers physical, behavioral, cognitive, psychosocial, functional and environmental topics and serves as the basis for the member's individualized care plan (ICP). Providers have access to the HRA results and the ICP through the provider portal.
4. Based on the results of the health risk assessment, an ICP will be developed by the case manager working directly with the member, and the interdisciplinary care team (ICT) to address identified needs. The care plan includes interventions designed to educate, inform and serve as an advocate for our members. Use of community resources is facilitated for the member, and benefits are coordinated between Medicare and Medicaid for our dual special needs members. The member's care plan will coordinate with and support your medical plan of care
5. An ICT is assigned to each member and is responsible for reviewing the care plans, collaborating with you and other network providers and providing recommendations for management of care. You and/or your patient may be asked to participate in the care planning and management of the plan of care.
6. We have a contracted provider network having special expertise to manage the special needs population and monitor the use of clinical practice guidelines by the contracted providers. Roles of providers include advocating, informing and educating members, performing assessments, diagnosing and treating. If you believe our local network does not meet all of your members' specialized needs, and would like to recommend possible additions to our network, please contact provider relations at the number on the members' identification card or discuss with the case manager.
7. We are committed to effective, efficient communication with you. We have developed a communication system to support effective information between you, your members and our care team. Information from our internal systems are available to you through the provider portal and may assist you in managing your patient's care. You can access claim information, the care plan, medication history, HRA results and see other providers involved in providing care to the member. Our case managers may reach out to you to discuss needs identified during our case management process. We may also reach out by phone or fax to provide important information or to assist in coordinating care. You may also receive a copy of the care plan or a phone call from the case

manager asking you to review, make comments or recommendations about the care plan or the needs that have been identified during the care planning process. You may reach your members' care team by calling the number provided to you on any correspondence from us or the number on the members' identification card. General information is available online through the provider portal on our website.

8. We support transitions in care for your patients. Special needs plan members typically have many providers and may transition into and out of health care institutions. Our care management team may contact you and your patient related to certain types of transitions. If you are aware of an upcoming care transition for your patient and would like our team to assist in the coordination, please notify us at the number provided on the members' identification card. Care transition protocols and your role in this process are communicated in this manual.
9. Performance and health outcome measurements are collected, analyzed and reported to measure health outcomes and quality measures and also to evaluate the effectiveness of the model of care. These measurements are used by our Quality Management Program and include the following measures:
    - HEDIS — used to measure performance on dimensions of care and service
    - Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction survey
    - Health Outcomes Survey (HOS) member survey is multi-purpose and used to compute physician and mental component scores to measure the health status, while not limited to SNP members responses we use these results to assist us in the population assessment.
    - CMS Part C Reporting Elements, including benefit utilization, adverse events, organizational determinations and procedure frequency
    - Medication therapy measurement measures
    - Clinical and administrative/service quality improvement projects

SNP model of care training is required annually and available to providers, employees and contractors. The training may be provided to you in your provider manual, through newsletters, provider orientation, or on our provider portal.

Annual Program Evaluation

We conduct an annual evaluation of the model of care to identify any modifications that are needed and assess progress toward meeting the program goals. Throughout the year, we review our program to identify of any issues. The results of our defined goals are included as part of the program evaluation. When necessary, we develop action plans for goals that are not be trending toward our benchmarks. We compare our goals to the previous year to evaluate our progress toward our benchmarks. In most of our markets, we are meeting or exceeding in many areas. We are also showing an upward trend when we compare the year over year results. We continue to work on ways to improve our outreach to our members and improve our completion rates for the health risk assessments, individualized care plans and interdisciplinary care teams for each of our special needs plan members. We manage use of inpatient and emergency room services and have programs in place to address areas where we have opportunities for improvement. The goals related to managing transitions include access to the PCP and postdischarge management continue to improve in most markets. Preventive care goals are established for our programs and managed as part of the HEDIS program.

One of our desired outcomes as part of the model of care is to assist you in managing and coordinating care in order to improve the health status and outcomes of your patients. If you have any input regarding our model of care, we welcome your feedback.

4.2 Anthem Care Transition Protocols and Management

Assisting with the management of transitions is an important part of our case management and model of care. Members are at risk of fragmented and unsafe care during transitions between care settings and levels of care. To help members and caregivers navigate transitions successfully, assistance is provided through many touch points and through educational materials. Transitions in care refer to the movement between health care providers and settings and include changes in a member's level of care. Examples of transitions include transitions to and from: acute care, skilled nursing facility, custodial nursing facility, rehabilitation facility, home, home health care, and outpatient or ambulatory care centers. A team approach is necessary to assist the member with a successful transition. Managing transitions includes protocols such as assisting with logistical arrangements, providing education to the member and caregiver, coordination between health care professionals and a provider network with appropriate specialists who can address the complex needs of the special needs population. Transitional care includes both the receiving and sending aspects of the transfer. Transitional care management assists in providing continuity of care by creating an environment where the member and the provider are cooperatively involved in ongoing health care management with goal of providing access to high-quality, cost-effective medical care.

Personnel Responsible for Coordinating Care Transition

Providers are essential members of the ICT and should assist members by coordinating care and communicating with members of the ICT. Members are connected to the appropriate provider to care for their individual needs including any complex medical conditions. The PCP is responsible for coordinating and arranging referrals to the appropriate care provider.

When services are not a covered benefit, coordination with community resources occurs to meet the needs of the population. For our dual population, you are required to coordinate between Medicare and Medicaid. Coordination with Medicaid services includes coordination of benefits and also working with Medicaid case managers/service coordinators and providers of long-term services and supports (LTSS) to close care gaps.

Protocols outlining the expectations for managing transitions may be communicated to the provider network through newsletters, published in the provider manual or on the provider portal. Below are protocols when managing transitions

- Participate in the interdisciplinary care team meetings.
- Notify the member in advance of a planned transition.
- Provide documentation to the provider or facility about the member to assist in providing continuity of care.
- Communicate and follow up with the member about the transition process.
- Communicate health status and plan of care to the member.
- Provide a treatment plan/discharge instructions to the member prior to being discharged from one level of care to another.
- Provide relevant patient history to the receiving provider.
- Forward pertinent diagnostic results to treating providers.
- Communicate any test results and the treatment plan back to the referring provider.

We assist our members and providers in the management of transitions in multiple ways within our care management programs. The actions below represent some of the ways our care team works with our providers and members to coordinate care and assist in the management of transitions:

- Communicate with the provider to discuss the member's care needs as identified during case management or model of care activities.
- Assist the member in making appointments.

- Coordinate between Medicaid and Medicare benefits.
- Perform medication reconciliation.
- Arrange transportation.
- Refer the member to external or internal programs.
- Coordinate care with behavioral health services.
- Assist with arranging DME and home health services.
- Coordinate and facilitate transitions to the appropriate level of care.
- Provide the member with disease-specific education and self-management techniques.
- Contact high-risk members post-discharge to reduce unnecessary readmissions.
- During interactions with the member, communicate support is available from member services to serve as a central point of contact and assist during any transition.

5 ANTHEM MEDICARE ADVANTAGE COMPLAINTS, APPEALS, GRIEVANCES AND DISPUTES

5.1 Distinguishing between Provider and Medicare Advantage Member Complaints, Appeals and Grievances

Anthem has separate and distinct processes for requests to reconsider an Anthem decision on an authorization or request for payment upon claims submission. Upon processing of each request, assignment of liability for the service is determined. All Medicare Member liability denials are subject to the Medicare Complaint, Appeal and Grievance (MCAG) process as outlined in the *Member Appeals and Grievances* section. Disputes between the health plan and the provider that do not involve an adverse determination or liability for the Medicare Member would follow the Anthem Medicare Advantage participating provider appeals and dispute or nonparticipating provider payment dispute processes.

Providers must cooperate with Anthem and with members in providing necessary information to resolve the appeals within the required time frames. Providers must provide the pertinent medical records and any other relevant information upon request and when initiating an appeal. In some instances, providers must provide the records and information very quickly in order to allow Anthem to make an expedited decision. Your participation in and the member's election of the Medicare Advantage plan are an indication of consent to release those records as part of the health care operations.

Medicare Member Liability
Anthem has determined that a Medicare member is responsible for payment as the service(s) are determined to be not covered under the plan to which they are enrolled or is considered Medicare member cost share. Any time a member liability denial letter is issued, the member appeals process should be followed and **not** the provider appeals process. Medicare member liability is assigned when:

- The *Integrated Denial Notice* (*IDN*) is issued as per the *Medicare Managed Care Manual Chapter 13 Appeal rights with subsequent review by the Independent Review Entity (IRE).*
- *Notice of Medicare Non-Coverage* (*NOMNC*) is issued as per the *Medicare Managed Care Manual Chapter 13 Appeal rights with rights to pursue an appeal via the Quality Improvement Organization (QIO) or the plan directly*.
- An *Explanation of Benefits* (*EOB*) indicates there is member responsibility assigned to a claim processed.
- An *Explanation of Payment* (*EOP*) indicates there is member responsibility assigned to a claim processed.

Note: Members that are dually eligible, either as full benefit dual eligible or as part of a Medicare Savings Program, are protected from liability of Medicare premiums, deductible, coinsurance and copay amounts. This includes cost share being applied to this/these claims. Providers may not bill a dual eligible that has this coverage for any balance left unpaid (after submission to Medicare, a Medicare carrier and subsequently Medicaid) as specified in the *Balanced Budget Act of 1997*. Providers that service dual eligible beneficiaries must accept as payment in full the amounts paid by Medicare as well as any payment under the state Medicaid processing guidelines. Providers who balance bill the dual eligible beneficiary are in violation of these regulations and are subject to sanctions. Providers also may not accept dual eligible beneficiaries as 'private pay' in order to bill the patient directly and providers identified as continuing to bill dual eligible beneficiaries inappropriately will be reported to CMS for further action/investigation.

Participating Provider Liability
If Anthem has determined that the participating provider has failed to follow the terms and conditions of their contract either administratively or by not providing the clinical information needed to substantiate the services being requested for approval of payment, the participating provider is prohibited from billing a Medicare member for services unless the plan has determined member liability and issued the appropriate notices as above.

Nonparticipating Provider Liability
If Anthem has determined that the nonparticipating provider with the plan has failed to follow Medicare services unless the plan has determined member liability and issued the appropriate notices as above and has procedures for nonparticipating provider to follow.

5.2 New Provider Payment Disputes Process

The following information applies to Colorado and Nevada markets only at this time. All other markets will follow the existing Provider Claims Disputes Process documentation that has already been outlined within this manual.

5.3 Claim Payment Disputes

Provider Claim Payment Dispute process
If you disagree with the outcome of a claim, you may begin the provider payment dispute process. There are two types of submissions that are handled within the dispute process:

- **Provider Payment Dispute**: The claim has been finalized but you disagree with the amount that you were paid;
- **Provider Administrative Plea/Appeal**: The claim has been finalized, but you disagree with the administrative denial that has been applied. An administrative denial is applied within the claims process when it is determined that the provider failed to follow the terms and conditions of their contract. Examples of administrative denials are as follows: denials such as no prior authorization or late notification.

Please be aware, there are two common claim-related issues that are **not** considered claim payment disputes. To avoid confusion with claim payment disputes, these are briefly defined below. They are:

- Claim Inquiry: A question about a claim, but not a request to change a claim payment.
- Claims Correspondence: When Anthem requests further information to finalize a claim. Typically, these requests include medical records, itemized bills, or information about other insurance a member may have. A full list of correspondence related materials are in the correspondence section of this provider manual.

Claims that were denied for lack of medical necessity should follow the existing provider post-service appeal process. An example of a post-service medical necessity appeal scenario would be as follows:

- On clinical review, the services related to the prior authorization request were deemed not medically necessary but services were rendered and claim payment was denied. For more information on each of these, please refer to the appropriate section in this provider manual.

The Anthem provider payment dispute process consists of two internal steps. You will **not** be penalized for filing a claim payment dispute and no action is required by the member.

1. Claim Payment Reconsideration: This is first step in the provider payment dispute process. The reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.

2. Claim Payment Appeal: The second step in the provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal.

A claim payment dispute may be submitted for multiple reason(s) including:

- Contractual payment issues.
- Disagreements over reduced claims or zero-paid claims not related to medical necessity.
- Post-service authorization issues.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Retro-eligibility issues.
- Experimental/investigational procedure issues.
- Claim data issues.
- Timely filing issues.*

*Timely filing issues: Anthem will consider reimbursement of a claim which has been denied due to failure to meet timely filing if you can: 1) provide documentation the claim was submitted within the timely filing requirements or 2) demonstrate good cause exists.

5.4 Claim Payment Reconsideration

The first step in the Anthem claim payment dispute process is called the reconsideration. It is your initial request to investigate the outcome of a finalized claim. Please note, we cannot process a reconsideration without a finalized claim on file.

We accept reconsideration requests in writing, verbally and through our provider web portal within 120 calendar days from the date on the *Explanation of Payment* (*EOP*) (see below for further details on how to submit). Reconsiderations filed more than 120 days from the *EOP* will considered to be untimely and denied unless good cause can be established.

When submitting reconsiderations, please include as much information as you can to help us understand why you think the claim was not paid as you would expect.

The plan encourages providers to use our claims payment reconsideration process if you feel a claim was not processed correctly, however, this optional step is not required prior to filing a claim payment appeal**.**

If a reconsideration requires clinical expertise, it will be reviewed by appropriate clinical professionals.

The plan will make every effort to resolve the claims payment reconsideration within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

We will send you our decision in a determination letter when upholding our decision, which will include:

1. A statement of the provider's reconsideration request.
2. A statement of what action the plan intends to take or has taken.
3. The reason for the action.
4. Support for the action including applicable statutes, regulations, policies, claims, codes or provider manual references.

5. An explanation of the provider's right to request a claim payment appeal within 63 calendar days of the date of the reconsideration determination letter.
6. An address to submit the claim payment appeal.
7. A statement that the completion of the claim payment appeal process is a necessary requirement before requesting a state fair hearing.

If the decision results in a claim adjustment, the payment and *Explanation of Payment* (*EOP*) will be sent separately. Overturned decisions will result in an adjustment and EPOs.

5.5 Claim Payment Appeal

If you are dissatisfied with the outcome of a Reconsideration determination, you may submit a claim payment appeal.

We accept claim payment appeals through our provider website or in writing within 63 calendar days of the date on the reconsideration determination letter. Claim payment appeals received more than 63 calendar days after the explanation of payment or the claims reconsideration determination letter will be considered untimely and will be upheld unless good cause can be established.

When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the reconsideration determination was in error. Please note, we cannot process a claim payment appeal without a reconsideration on file.

If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate clinical professionals.

The plan will make every effort to resolve the claim payment appeal within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

The claim payment appeal determination letter will include:
1. A statement of the provider's claim payment appeal request.
2. A statement of what action the plan intends to take or has taken.
3. The reason for the action.
4. Support for the action including applicable statutes, regulations, policies, claims, codes or provider manual references.
5. A statement about how to submit a state fair hearing.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

5.6 How to submit a Claim Payment Dispute

We have several options when filing a claim payment dispute. They are described below.

- **Verbal (Reconsideration only):** Verbal submissions may be submitted by calling Provider Services.
- **Web Portal (Reconsideration and Claim Payment Appeal)**: The plan can receive reconsiderations and claim payment appeals via the secure Availity Payment Appeal Tool at **https://www.availity.com.** Supporting documentation can be uploaded on the Portal. You will receive immediate acknowledgement of your web submission.

- **Written (Reconsideration and Claim Payment Appeal):** Written reconsiderations and claim payment appeals should be mailed, along with the *Claim Payment Appeal Form* or the *Reconsideration Form* to:
  - Provider Payment Disputes
    P.O. Box 61599
    Virginia Beach, VA 23466-1599

Required Documentation for Claims Payment Disputes
The health plan requires the following information when submitting a claim payment dispute (reconsideration or claim payment appeal):

- Your name, address, phone number, email, and either your NPI or TIN.
- The member's name and their Medicaid or Medicare ID number.
- A listing of disputed claims, which should include the claim number and the date(s) of service(s).
- All supporting statements and documentation.

Claim Inquiry
A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but outcome of the claim inquiry may result in the initiation of the claim payment dispute. in other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

Our Provider Experience program helps you with claim inquiries. Call Provider Services and select the Claims prompt within our voice portal. We connect you with a dedicated resource team, called the Provider Service Unit (PSU), to ensure:

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact, issue resolution rates.
- Significantly improved turnaround time of inquiry resolution.
- Increased outreach communication to keep you informed of your inquiry status.

The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue.

Claim Correspondence
Claim correspondence is different from a payment dispute. Correspondence is when the plan requires more information in order to finalize a claim. Typically, Anthem makes the request for this information through the *EOP*. The claim or part of the claim may, in fact, be denied, but it is only because more information is required to process the claim. Once the information is received, Anthem will use it to finalize the claim.

The following table provides examples the most common correspondence issues along with guidance on the most efficient ways to resolve them.

Type of Issue	What Do I Need to Do?
Rejected Claim(s)	Use the **EDI Hotline** at **1-800-590-5745** when your claim was submitted electronically but was never paid or was rejected. We're available to assist you with setup questions and help resolve submission issues or electronic claims rejections.
EOP Requests for Supporting Documentation (*Sterilization/ Hysterectomy/Abortion Consent Forms*, itemized bills and invoices)	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the supporting documentation to: Claims Correspondence P.O. Box 61599

	Virginia Beach, VA 23466-1599
EOP Requests for Medical Records	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the medical records to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
Need to submit a Corrected Claim due to errors or changes on original submission	Submit a *Claim Correspondence Form* and your corrected claim to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599 Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received timely, a corrected claim must be received within 365 days of the date of service. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to Anthem to adjust the other health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI *EOB.*
Submission of coordination of benefits (COB)/third-party liability (TPL) information	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the COB/TPL information to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
Emergency Room Payment Review	Submit a Claim Correspondence form, a copy of your EOP and the medical records to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599

6 ANTHEM MEDICARE ADVANTAGE PARTICIPATING PROVIDER APPEALS AND DISPUTES

6.1 Participating Provider Appeals

Participating provider appeals follow the standard Anthem process for provider appeals. Anthem participating providers may initiate provider appeals under the provider complaint and appeal procedures. The processing of a particular provider appeal may vary depending on whether or not it involves a review of medical necessity. The provider complaint and appeals procedures contain alternative steps, based on product and state, as necessary to comply with regulatory and accreditation requirements.

The Provider Complaint and Appeal Procedures are designed to permit Anthem to examine issues fully and fairly before completion of the Anthem internal review process. Special processes apply to appeals that involve utilization review decisions on clinical benefits. Anthem typically determines provider appeals within 60 days (for utilization review cases) or 60 days (for other cases) when sufficient information is received to make a decision.

6.2 Medicare Participating Provider Standard Appeal

A formal request for review of a previous Anthem decision where medical necessity was not established where provider liability was assigned (see original decision letter) for services already rendered.

Provider Medical Necessity Appeals Responsibility

All requests must be:

- Submitted in writing.
- Submitted within 180 days from the Anthem decision letter date.*
- Include a cover letter with:
    - Member identifiable information
    - Date(s) of service in question
    - Specific rationale as to why the services did in fact meet medical criteria and reference specifics within the medical record to refute Anthems original decision
- Include necessary attachments:
    - Copy of the original Anthem decision
    - All applicable medical records

N**ote**: Anthem will not request additional records to support the provider's argument and expects the provider to submit the necessary information to substantiate their request for payment.

Mail to:

Medicare Complaints, Appeals and Grievances (MCAG)
Attention: Medical Necessity Provider Appeals
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

Providing the above information will enable the Anthem Participating Provider Appeals team to properly and timely review requests within 60 business days. Requests that do not follow the above may be delayed.

* Days from original denial date may differ, depending upon the contract and/or state requirement (MMP/DSNP).

6.3 Medicare Participating Provider Administrative Plea/Appeal

A formal request for review of a previous Anthem decision where a determination was made that the participating provider failed to follow administrative rules and provider liability was assigned (see original decision letter) where services have already been rendered.

Appeals for failure to provide timely notification will not be reviewed clinically until the late notification denial is resolved.

Provider Administrative Plea/Appeals Responsibility

All requests must be:

- Submitted in writing.
- Submitted within 180 days from the Anthem decision letter date.*
- Include a cover letter with:
    - Member identifiable information
    - Date(s) of service in question
    - Specific rationale as to why the services did in fact meet medical criteria and reference specifics within the medical record to refute Anthems original decision
- Include necessary attachments:
    - Copy of the original Anthem decision
    - All applicable medical records

Note: In the event Anthem waives the administrative requirement, should your request require a medical review, Anthem will not request additional records to support the provider's argument and expects the provider to submit the necessary information to substantiate their request for payment.

Mail to:

Medicare Complaints, Appeals and Grievances (MCAG)
Attention: Administrative Provider Plea/Appeals
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

Providing the above information will enable Anthems Participating Provider Appeals team to properly and timely review requests within 60 business days. In the event Anthem waives the administrative requirement, the request will be transferred to the appropriate area for review under that process and applicable time frames. Requests that do not follow all of the above may be delayed.

* Days from original denial date may differ, depending upon the contract and/or state requirement (MMP/DSNP).

6.4 Medicare Provider Payment Disputes Process (Claims Re-review)

- For all markets except for New Mexico, Tennessee, Washington New Jersey, Texas, California, Colorado, and Nevada

A formal request from a provider contesting the paid amount on a claim which does not include a medical necessity and claims payment determinations have already been rendered.

All payment disputes must be:

- Submitted in writing.
- Submitted within 60 days from the Anthem original payment.

- Include a cover letter with:
    - Claim Identifiable information
    - Specific rationale as to why the payment made is not appropriate or needs adjustment
- Include necessary attachments:
    - Copy of the original Anthem payment (*EOP*)
    - All applicable medical records or other attachments supporting additional payment

Note: Anthem will not request additional information and expects the provider to submit the necessary information to substantiate their request for additional payment
Mail to:

Medicare Payment Dispute Unit
P.O. Box 110
145 S Pioneer Road
Fond du Lac, WI 54935

Providing the above information will enable Anthems Payment Dispute Unit to properly and timely review requests. Requests that do not follow all of the above may be delayed.

* Days from original denial date may differ, depending upon the contract and/or state requirement (MMP/DSNP).

7 ANTHEM MEDICARE ADVANTAGE NONPARTICIPATING PROVIDER PAYMENT DISPUTES AND APPEALS

7.1 Nonparticipating Provider Payment Disputes

If, after a claim has been adjudicated, a nonparticipating provider contends that our decision to pay for a different service from the one originally billed or believe they would have received a different payment under Original Medicare, the nonparticipating provider payment dispute resolution process can be used. Notification will be provided to the nonparticipating provider at each step of the process.

7.2 Nonparticipating Provider Appeals Rights

If a claim is partially or fully denied for payment, the nonparticipating provider must request a reconsideration of the denial within 60 calendar days from the remittance notification. When submitting the reconsideration of the denial of payment on a claim, a signed *Waiver of Liability Statement* must be included. To obtain this form, visit **https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms.html**.

The purpose of the *Waiver of Liability Statement* is to hold the enrollee harmless regardless of the outcome of the appeal.

With the appeal, the nonparticipating provider should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's argument for reimbursement. **The appeal must be in writing and mailed.**

Please mail the appeal to this address.
Grievances and Appeals
Mailstop: OH0205-A537
4361 Irwin Simpson Rd
Mason, Ohio 45040

8 ANTHEM MEDICARE MEMBER COMPLAINTS, APPEALS AND GRIEVANCES

8.1 Distinguishing Between Member Appeals and Member Grievances

Complaints are considered any expression of dissatisfaction to a Medicare health plan, provider, facility or Quality Improvement Organization (QIO) by an enrollee made orally or in writing. There are two procedures for resolving MA member complaints: the Medicare member **appeals** process and the Medicare member **grievance** process. All member concerns are resolved through one of these mechanisms. The member's specific concern dictates which process is used. Therefore, it is important for the physician to be aware of the difference between appeals and grievances.

8.2 Medicare Member Liability Appeals

A member appeal is the type of complaint a member (or authorized representative) makes when the member wants Anthem to reconsider and change an initial coverage/organization determination (by Anthem or a provider) about what services, benefits or prescription drugs are necessary or covered or whether Anthem will reimburse for a service, a benefit or a prescription drug.

An appeal refers to any of the procedures that deal with a request to review a denial of payment or services. If a member believes he or she is entitled to receive a certain service and Anthem denies it, the member has the right to appeal. It is important to follow the directions in the denial letter issued to ensure the proper appeals process is followed.

A member may appeal:

- An adverse initial organization determination by Anthem or a provider concerning authorization for or termination of coverage of a health care service
- An adverse initial organization determination by Anthem concerning reimbursement for a health care service
- An adverse initial organization determination by Anthem concerning a refusal to reimburse for a health service already received if the refusal would result in the member being financially liable for the service
- An adverse coverage determination by Anthem or a provider concerning authorization for prescription drugs

Appeals should be sent to:

Medicare Complaints, Appeals and Grievances (MCAG)
Attention: Member Appeals Unit
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

All Medicare member concerns that do not involve an initial determination are considered grievances and are addressed through the grievance process.

8.3 Participating Provider Responsibilities in the Medicare Member Appeals Process

- Physicians can request standard service or expedited appeals on behalf of their members; However, if not requested specifically by the attending physician, an *Appointment of Representative Form* to submit an appeal on behalf of a Medicare member, may be required. The *Appointment of Representative Form* can be found online and downloaded at **https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms.html**.
- When submitting an appeal, provide all medical records and documentation to support the appeal at that time. If additional information is needed, the request for information will delay processing of the appeal
- Expedited appeals should only be requested if the normal time period for an appeal could jeopardize the member's life, health or ability to regain maximum function.
- The CMS guidelines should be utilized when requesting services and initiating the appeals process

Appeal time frames

- Members or their authorized representatives have 60 days from the date of the denial of service to file an appeal. The 60-day filing deadline may be extended where good cause can be shown.
- For standard service appeals, service and payment issues must be resolved within 30 calendar days from the date the request was received.
  - If the normal time period for an appeal could jeopardize the member's life, health or ability to regain maximum function, a request for an expedited appeals may be submitted orally or in writing. Such appeals generally are resolved within 72 hours, unless it is in the member's interest to extend this time period.
- For payment appeals, service and payment issues must be resolved within 60 calendar days from the date the request was received. All payment appeals must be submitted in writing.

8.4 Further Appeal Rights

If Anthem is unable to reverse the original denial decision in whole or part, the following additional steps will be taken:

- Anthem will forward the appeal to an Independent Review Organization (IRO) contracted with the federal government. The IRO will review the appeal and make a decision:
  - Within 72 hours if expedited.
  - Within 30 days if the appeal is related to authorization for health care.*
  - Within 60 days if the appeal involves reimbursement for care.*
  - Prescription drug appeals are not forwarded to the IRO by Anthem but may be requested by the member or representative; information will be provided on this process during the Anthem Medicare member appeals process.
- If the IRO issues an adverse decision (not in the member's favor) and the amount at issue meets a specified dollar threshold, the member may appeal to an Administrative Law Judge (ALJ).
- If the member is not satisfied with the ALJ's decision, the member may request review by the Medicare Appeals Council. If the Medicare Appeals Council refuses to hear the case or issues an adverse decision, the member may be able to appeal to a federal court.

* Some plans may have different turnaround times due to state requirements.

Hospital discharge appeals and QIO review process

Hospital discharges are subject to the expedited member appeal process. CMS has determined that Medicare Advantage members wishing to appeal an inpatient hospital discharge must request an

immediate review from the appropriate Quality Improvement Organization (QIO) authorized by Medicare to review the hospital care provided to Medicare patients.

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

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

If the QIO agrees with the physician's discharge decision, the member will be responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day the QIO provides notification of its decision. If the QIO disagrees with the physician's discharge decision, the member is not responsible for paying the cost of additional hospital days. If an MA member misses the deadline to file for an immediate QIO review, then he/she may request an expedited appeal. In this case, the member does not have automatic financial protection during the course of the expedited appeal and may be financially liable for paying for the cost of the additional hospital days if the original decision to discharge is upheld upon appeal.

8.5 Medicare Member Grievance

A Medicare member grievance is the type of complaint a member makes regarding any other type of problem with Anthem or a provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room and the cleanliness of the provider's facilities are grievances.

Anthem must accept grievances from members orally or in writing within 60 days of the event. Anthem must make a decision and respond to the grievance within 30 days.* A member can request an expedited grievance, in which case Anthem has 24 hours to respond. An expedited grievance can only be initiated if Anthem refuses to grant the member an expedited organization/coverage determination or an expedited reconsideration/redetermination. Anthem can request up to 14 additional days to respond to a grievance with good reason.

* Some plans may have different turnaround times due to state requirements.

8.6 Resolving Medicare Member Grievances

If a Medicare member has a grievance about Anthem, the Medicare Advantage plan, a provider or any other issue, providers should instruct the member to call Member Services at the number located on the back of their ID card or send a written grievance to:

Medicare Complaints, Appeals and Grievances (MCAG)
Attention: Member Grievance Unit
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

9 REIMBURSEMENT POLICIES

Reimbursement Policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Anthem benefit plan. These policies can be accessed on the provider site **here**. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. Covered services do not guarantee reimbursement unless specific criteria are met.

You must follow proper billing and submission guidelines, including using industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes which indicate the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current *Reimbursement Policies* are not followed, Anthem may:

- Reject or deny the claim
- Recover and/or recoup claim payment

Anthem *Reimbursement Policies* are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however Anthem strives to minimize these variations.

9.1 Reimbursement Hierarchy

Claims submitted for payments must meet all aspects of criteria for reimbursements. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity, authorization requirements or stipulations within a *Reimbursement Policy*. Neither payment rates nor methodology are considered to be conditions of payments.

9.2 Review Schedules and Updates

Reimbursement Policies undergo reviews for updates to state contracts, federal or CMS requirements and/or Anthem business decisions. We reserve the right to review and revise our policies when necessary. *Reimbursement Policies* go through a review every two years for updates to state, federal or CMS contracts and/or requirements. When there is an update we will publish the most current policy on the provider website at the link above.

9.3 Medical Coding

The Medical Coding department ensures that correct coding guidelines have been applied consistently throughout Anthem. Those guidelines include, but are not limited to:

- Correct modifier use.
- Effective date of transaction code sets (CPT, HCPCS, ICD diagnosis/procedures, revenue codes, etc.)
- Code editing rules are appropriately applied and within regulatory requirements.
- Analysis of codes, code definition and appropriate use.

9.4 Reimbursement by Code Definition

Anthem allows reimbursement for covered services based on their procedure code definitions or descriptors, as opposed to their appearance under particular CPT categories or sections, unless otherwise noted by state or provider contracts, or state, federal or CMS requirements. There are eight CPT sections:

1. Evaluations and management
2. Anesthesia
3. Surgery
4. Radiology (nuclear medicine and diagnostic imaging)
5. Pathology and laboratory
6. Medicine
7. Category II codes: supplemental tracking codes that can be used for performance measurement
8. Category III codes: temporary codes for emerging technology, services or procedures

9.5 Anthem Medicare Advantage Coordination of Benefits

Anthem and its providers agree Medicare coverage is secondary and the Medicaid program is the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicare members. When Anthem is aware of third-party resources prior to paying for a medical service, it will follow appropriate coordination of benefits standards by either rejecting a provider's claim and redirecting the provider to bill the appropriate insurance carrier or, if Anthem does not become aware of the resource until sometime after payment for the service was rendered, by pursuing post payment recovery of the expenditure. Providers must not seek recovery in excess of the applicable Medicare and/or Medicaid payable amounts.

Anthem will follow appropriate coordination of benefits standards for trauma-related claims where third-party resources are identified prior to payment. Otherwise, Anthem will follow a pay and pursue policy on prospective and potential subrogation cases. Paid claims are reviewed and researched postpayment to determine likely cases based on information obtained through communications with members and providers. Anthem handles the filing of liens and settlement negotiations both internally and externally via its vendors.

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

10 FORMS

Anthem Blue Cross and Blue Shield
Medicare Advantage

Provider Authorization to Adjust Claims and Create Claim Offsets

Submit this completed form with all supporting documentation to ensure proper processing of your request to adjust claims as detailed below. The adjustments will result in overpayments being withheld from future claims payments.

Provider name	
Provider NPI	
Provider tax identification number	
Provider contact information	
Cost Containment project number (if applicable)	
Document identification number (if applicable)	
Total recoupment dollar amount	

Please list claim information below if the *Cost Containment Letter* or other supporting claim/member detail is not provided with this request.

Claim number	**Member number**	**Service dates**	**Recoupment amount**
Recoupment reason			

Claim number	**Member number**	**Service dates**	**Recoupment amount**
Recoupment reason			
Claim number	**Member number**	**Service dates**	**Recoupment amount**
Recoupment reason			
Claim number	**Member number**	**Service dates**	**Recoupment amount**
Recoupment reason			
Claim number	**Member number**	**Service dates**	**Recoupment amount**
Recoupment reason			
Claim number	**Member number**	**Service dates**	**Recoupment amount**
Recoupment reason			

If your request for recoupment exceeds the space provided, please attach an excel file that includes all the data noted above. For questions related to the completion of this form, please call Provider Services at the number on the back of the member's ID card.

I authorize Anthem Blue Cross and Blue Shield (Anthem) to proceed with adjusting the claims as listed on this form or per separate document that supports this request.

_____

Print name Signature

Mail this form to:
Attn: Cost Containment – Disputes
Anthem Blue Cross and Blue Shield
P. O. Box 62427
Virginia Beach, VA 23466-2437

Note: Do not use this form if you are submitting a refund check. If you would like to submit a refund, please use the *Refund Notification Form* on the provider website. Mail a check along with the supporting documentation to:

Attn: Cost Containment – Payments
Anthem Blue Cross and Blue Shield
P.O. Box 933657
Atlanta, GA 31193-3657

Anthem Blue Cross and Blue Shield
Medicare Advantage

Overpayment Refund Notification Form

In order for an overpayment refund to be processed in a timely manner, please submit a completed form with all refund checks and supporting documentation. If the refund check you are submitting is an Anthem Blue Cross and Blue Shield check, please include a completed form specifying the reason for the check return.

Provider name/contact	
Contact number	
Provider ID	
Provider tax ID	
Subscriber ID	
DCN number (Displayed on CCU Letter)	
Member name	
Member account number	
Date of service	
Total billed charges	

Total check amount:
$_____

Claim number(s):

Reason for refund or check return:

☐ Health plan letter
☐ Contract rate change
☐ Duplicate payment

☐ Incorrect member
☐ Incorrect provider
☐ Negative balance
☐ Other health insurance/third-party liability
☐ Payment error
☐ Billed in error/adjusted charge
☐ Other: _____

All refund checks should be mailed with a copy of this form to:
Anthem Blue Cross and Blue Shield
P.O. Box 933657
Atlanta, GA 31193-3657

Once the Cost Containment Unit has reviewed the overpayment, you will receive a letter explaining the details of the reconciliation. Thank you for completing this *Overpayment Refund Notification Form*.

ABSCRPM-0002-19 December 2019

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