Provider Manual

Medi-Cal Managed Care

Major Risk Medical Insurance Program

Anthem BlueCross

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1 | INTRODUCTION

WELCOME

Thank you for being part of the Anthem Blue Cross family of health care services.

Anthem Blue Cross has been selected by the California Department of Health Care Services (DHCS) to provide health care services for Medi-Cal Managed Care (Medi-Cal) members in the following counties:

- Alameda
- Alpine
- Amador
- Butte
- Calaveras
- Colusa
- Contra Costa
- El Dorado
- Fresno
- Glenn
- Inyo
- Kings
- Madera
- Mariposa
- Mono
- Nevada
- Placer
- Plumas
- Sacramento
- San Benito
- San Francisco
- Santa Clara
- Sierra
- Sutter
- Tehama
- Tulare
- Tuolumne
- Yuba

Anthem Blue Cross partners with L.A. Care Health Plan to provide health care services for Medi-Cal members in the following county:

- Los Angeles

Medi-Cal provides health care coverage for California's most vulnerable low-income citizens who lack health insurance.

Medi-Cal is the second largest source of health care coverage in California. Anthem Blue Cross has a long-standing history of providing Medi-Cal services to Californians. In fact, Anthem Blue Cross was one of the first Medi-Cal managed care organizations (MCOs).

USING THIS MANUAL

This *Provider Manual* is designed for Anthem Blue Cross contracted providers. Our goal is to create a useful reference guide for you and your office staff.

Providers contracted with an independent physician association (IPA) or other provider organization may have separate policies and procedures. Please contact the organization's administrator for details.

We recognize that managing our members' health can be a complex undertaking. It requires familiarity with the rules and requirements of a system that encompasses a wide array of health care services and responsibilities.

This includes everything from initial health assessments to case management and from proper storage of medical records to billing for emergencies. With that in mind, we've divided this manual into broad sections that reflect your questions, concerns and responsibilities before and after an Anthem Blue Cross member walks through your doors. This manual is available to you on our website at:

https://mediproviders.anthem.com/ca.

Select any topic in the Table of Contents and you will be automatically redirected to that topic's location within the manual. Select any web address and you will be redirected to that site. Each chapter may also contain cross-links to other chapters, important phone numbers, and our website or outside websites containing additional information.

Throughout this manual, there are instances where information is provided as a sample or example. This information is meant for illustration purposes only and is not intended to be used or relied upon in any circumstance or instance. If you have any questions about the content of this manual, please contact our Customer Care Center or your provider network representative.

DEFINITIONS

Provider: Any individual or entity that is engaged in the delivery of Medi-Cal services, or ordering or referring for those services, and is legally authorized to do so by DHCS.

LEGAL AND ADMINISTRATIVE REQUIREMENTS

Websites

The Anthem Blue Cross website and this manual may contain links and references to internet sites owned and maintained by third parties. Neither Anthem Blue Cross nor its related affiliated companies operate or control in any respect any information, products or services on third-party sites. Such information, products, services and related materials are provided as is without warranties of any kind, either expressed or implied, to the fullest extent permitted under applicable laws.

Anthem Blue Cross disclaims all warranties, expressed or implied, including but not limited to implied warranties of merchantability and fitness. Anthem Blue Cross does not warrant or make any representations regarding the use or results of the use of third-party materials in terms of correctness, accuracy, timeliness, reliability or otherwise.

The information contained in this manual will be updated regularly and is subject to change. This section provides specific information on the legal obligations of being part of the Anthem Blue Cross network.

This manual provides standards for services to members of the Medi-Cal and MRMIP programs. It does not establish standards for services to any other members of Anthem Blue Cross or its affiliates. If a section of the manual applies only to a specific program, that program will be indicated. If there is no such indication, the information is applicable to all programs.

By accepting this manual, Anthem Blue Cross providers agree to use this manual solely for the purposes of referencing information regarding the provision of medical services to Medi-Cal and MRMIP members who have chosen Anthem Blue Cross as their health plan.

This manual does not obligate providers to provide services to members enrolled in any of these programs unless the provider is under contract with Anthem Blue Cross to provide services in one or more of these programs. Providers are only required to follow the standards in this manual that are applicable to the program in which the member is currently enrolled.

UPDATES AND CHANGES

The *Provider Manual*, as part of your Provider Agreement and related Addendums, may be updated at any time and is subject to change. In the event of an inconsistency between information contained in the manual and the Agreement between you or your facility and Anthem Blue Cross, the Agreement shall govern.

In the event of a material change to the Provider Manual, we will make all reasonable efforts to notify you in advance of such change through web-posted newsletters, fax communications and other mailings. In such cases, the most recently published information should supersede all previous information and be considered the current directive.

The manual is not intended to be a complete statement of all Anthem Blue Cross policies or procedures. Other policies and procedures not included in this manual may be posted on our website or published in specially targeted communications, including but not limited to letters, bulletins and newsletters.

This manual does not contain legal, tax or medical advice. Please consult with your own advisors for such advice.

WEBSITES AND COMMUNITY RESOURCES

A wide array of valuable tools, information and forms are available on our websites below:

- **www.anthem.com/ca/medi-cal**
- **https://mediproviders.anthem.com/ca**
- **https://provider2.anthem.com/wps/portal/ebpmybcc**

ONLINE TOOLS FOR PROVIDERS

The **Availity Portal** is a secure website for Anthem Blue Cross eligibility, benefits and claim status inquiry functionality. All participating providers must register for Availity to access these functions and additional value-added features and services.

ProviderAccess is The Anthem Blue Cross provider web portal (a secure website) that is available to contracted health care providers. This site includes news and information, provider manuals, policies and procedures, and provider forms.

It also includes claims reporting, Remittance Advice Inquiry, Clear Claim Connection and much more. All participating providers must register for ProviderAccess to also access these functions.

ProviderAccess and Availity will minimize time spent on the telephone with Customer Service and allow more time for you to spend with your patients. In fact, it may eliminate 80% of routine inquiries to Anthem Blue Cross.

Both secure websites are available 24 hours a day, 7 days a week, except during scheduled maintenance and national holidays. They also offer printer-friendly format on all information screens.

THE AVAILITY PORTAL

To gain access to the Availity Portal:

- Go to **www.availity.com**.

1. Select **Register**.
2. Select **Get Started**.
3. Complete the online registration form.

- If you have questions about registering for the Availity Portal, contact Availity Client Services at **1-800-282-4548**.

PATIENT360 (AVAILITY)

Patient360 is real-time dashboard that gives you a robust picture of a patient's health and treatment history and will help you facilitate care coordination. You can drill down to specific items in a patient's medical record to retrieve demographic information, care summaries, claims details, authorization details, and pharmacy information.

With this level of detail at your fingertips, you will be able to:

- Spot utilization and pharmacy patterns.
- Avoid service duplication.
- Identify care gaps and trends.
- Coordinate care more effectively.
- Reduce the number of communications needed between PCPs and case managers.

Patient360 is offered on the Availity Portal. This online application lets you quickly retrieve detailed records about your Anthem Blue Cross patients. Patient360 replaces the Patient Care Summary that was previously accessed through *Eligibility and Benefits* on the Availity Portal. It will also replace *Member Medical History Plus (MMH Plus)*.

You must first be assigned the Patient360 role in the Availity Portal; administrators can make this assignment within the *Clinical Roles* options. Then navigate to Patient360 using one of the methods outlined on the following page.

Method 1

Select **Patient Registration** from the top menu bar in the Availity Portal.

1. Choose **Eligibility and Benefits**.
2. Complete the required fields on the *Eligibility and Benefits* screen.
3. Select the Patient360 link on the member's benefit screen.
4. Enter the member's information in the required fields.

Method 2

Select **Payer Spaces** from the top menu bar in the Availity Portal.

1. Choose the Anthem Blue Cross tile.
2. Select **Patient360** located on the *Applications* page.
3. Enter the member's information in the required fields.

If you have other questions about Patient360, please contact your local network representative.

THE PROVIDER ACCESS WEB PORTAL

To gain access to the ProviderAccess Web Portal, use the following link.

https://provider2.anthem.com/wps/portal/ebpmybcc

HEALTH EDUCATION AND CULTURAL AND LINGUISTIC NEEDS

Health education classes and cultural and linguistic requests are available at no charge to Anthem Blue Cross members enrolled in Medi-Cal and are accessible upon self-referral or referral by Anthem Blue Cross network providers. To refer a member, please use the *Health Education and Cultural Linguistic Needs Referral Form* available on our website at the following address.

Providers can refer members to health education classes using the *Referral Form* on the provider website below:

https://mediproviders.anthem.com/ca/pages/health-education-programs.aspx

Additional information on interpreter services is available on the *Free Interpreting Services* page of our website at:

https://mediproviders.anthem.com/ca/pages/free-interpreting-services.aspx

☎ For after-hours telephone interpreter services, members can call the 24/7 NurseLine at **1-800-224-0336**, **TTY 1-800-368-4424**.

MEDICAL APPOINTMENT STANDARDS

Health care providers must make appointments for members from the time of request as follows:

Emergency examination	Immediate access 24 hours/7 days a week
Urgent (sick) examination	Within 48 hours of request if authorization is not required or within 96 hours of request if authorization is required or as clinically indicated
Routine primary care examination (nonurgent)	Within 10 business days of request
Nonurgent consults/specialty referrals	Within 15 business days of request
Nonurgent care with nonphysician mental health providers (where applicable)	Within 10 business days of request
Nonurgent ancillary	Within 15 business days of request
Initial health assessments	Within 120 days of enrollment
Preventive care visits	Within 14 days of request
Routine physicals	Within 30 days of request

Initial health assessments (under age 21)	
Children under the age of 18 months	Within 120 days of enrollment or within American Academy of Pediatrics (AAP) guidelines, whichever is less
Children aged 19 months to 20 years of age	Within 120 days of enrollment
Prenatal and postpartum visits	
First prenatal visit	Within 10 days of request
1st and 2nd trimester	Within 7 days of request
3rd trimester	Within 3 days of request
High-risk pregnancy	Within 3 days of identification
Postpartum	Between 21 and 56 days after delivery

CONTACT INFORMATION

The following resource grid is a consolidation of the most-used phone and fax numbers, websites and addresses found within the manual itself. We've also included other valuable contact information for you and your staff.

STATE OF CALIFORNIA

Health services programs handled by the state:

State services contacts	Phone/fax numbers	Other contact information
Automated Eligibility Verification System (AEVS)	**1-800-456-2387**	
California Children's Services (CCS)	Phone numbers are county-specific. Los Angeles County Phone: **1-800-288-4584** Fax: **1-800-924-1154**	Referrals: **www.dhcs.ca.gov/services/ccs/Pages/default.aspx**
Community-Based Adult Services (CBAS)	**California Department of Aging:** Phone within California: **1-800-510-2020** Phone outside of California: **1-800-677-1116**	**https://www.aging.ca.gov/Programs/#CBAS**
Denti-Cal	**1-800-423-0507** 8 a.m. - 5 p.m., Monday through Friday	**www.denti-cal.ca.gov**
Department of Health Care Services Medi-Cal Managed Care Ombudsman	**1-800-452-8609**	**www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOfficeoftheOmbudsman.aspx**
Department of Health Care Services Office of Family Planning	**1-800-942-1054**	**www.dhcs.ca.gov/services/ofp/Pages/OfficeofFamilyPlanning.aspx**
Department of Social Services Public Inquiry and Response Unit	**1-800-952-5253**	
Department of Managed Health Care	**1-877-525-1295**	**www.dmhc.ca.gov**
Indian Health Services	**1-916-930-3927**	**www.ihs.gov/Calfornia**
Medi-Cal Telephone Service Center	**1-800-541-5555**	

ANTHEM BLUE CROSS

Contact information related to Anthem Blue Cross Medi-Cal programs:

Contact	Outside Los Angeles County	Inside Los Angeles County	Hours of operation (PT)	Address, email, fax and/or website
Availity	**1-800-282-4548**			**www.availity.com**
Utilization Management: **Medi-Cal**	**1-888-831-2246**		8 a.m. - 5 p.m., Mon - Fri	Fax: **1-800-754-4708** Behavioral Health: Medi-calBHUM@wellpoint.com Fax: **1-855-473-7902**
Utilization Management: **MRMIP**	**1-877-273-4193**		8 a.m. - 5 p.m., Mon - Fri	Fax: **1-800-754-4708**
Utilization Management: **Delegated Groups to Perform UM**	**1-888-831-2246**		8 a.m. - 5 p.m., Mon - Fri	Fax: **1-888-232-0708**
Case Management	**1-888-334-0870**		8 a.m. - 5 p.m., Mon - Fri	Fax: **1-866-333-4827**
Claims: **Follow-Up**	Anthem Blue Cross, P.O. Box 60007, Los Angeles, CA 90060-0007			
Claims: **Overpayment Recovery**	Overpayment Recovery Anthem Blue Cross P. O. Box 92420 Cleveland, OH 44135		Overnight packages: Overpayment Recovery Anthem Blue Cross Lockbox 92420 4100 West 150th St. Cleveland, OH 44135	
Claims: EDI	Availity Client Services at: 1-800-Availity (1-800-282-4548)		8 a.m. - 7:30 p.m., Mon – Fri Eastern Time	**www.anthem.com/edi**
Claims: Paper	Anthem Blue Cross, P.O. Box 60007, Los Angeles, CA 90060-0007			

Contact	Outside Los Angeles County	Inside Los Angeles County	Hours of operation (PT)	Address, email, fax and/or website
Community-Based Adult Services (CBAS)	**1-855-871-4899**		8 a.m. - 5 p.m., Mon - Fri	**https://www.aging.ca.gov/Programs/#CBAS** **Fax: 855-336-4041**
Network Relations Department	Central CA: **1-877-811-3113** Northern CA: **1-888-252-6331**	Los Angeles: **1-866-465-2272**	8 a.m. - 5 p.m., Mon - Fri	
Customer Care Center	**1-800-407-4627** **1-888-757-6034 (TTY)**	**1-888-285-7801** L.A. Care: **1-866-522-2736**	7 a.m. - 7 p.m., Mon to Fri	For after-hours services, please call 24/7 NurseLine (see below).
MRMIP	**1-877-687-0549** **1-888-757-6034 (TTY)**	**1-877-687-0549** **1-888-757-6034 (TTY)**	8:30 a.m. - 7 p.m., Mon - Fri	**www.dhcs.ca.gov** For after-hours services, please call 24/7 NurseLine (see below).
IngenioRx Help for Pharmacists	**1-833-253-4454**	**1-833-253-4454**	5 a.m. - 10 p.m., Mon - Fri 6 a.m. - 3 p.m. Sat/Sun	Request for formulary changes: Anthem Prescription Mgt., LLC Attn: Formulary Department P.O. Box 746000 Cincinnati, OH 45274-6000
Pharmacy Prior Authorization Center	**1-844-410-0746**	**1- 1-844-410-0746**	7 a.m. - 7 p.m., Mon - Fri	**Fax: 1-844-474-3345**
Fraud and Abuse: **Medi-Cal**	**1-800-407-4627** or **1-888-231-5044** (Blue Cross of California Fraud Hotline)	**1-888-285-7801**	7 a.m. - 7 p.m., Mon to Fri	Fax: **1-866-454-3990**

2 | QUICK REFERENCE

Contact	Outside Los Angeles County	Inside Los Angeles County	Hours of operation (PT)	Address, email, fax and/or website
Fraud and Abuse: **MRMIP**	**1-877-687-0549**	**1-877-687-0549**	7 a.m. - 7 p.m., Mon - Fri	
Grievances & Appeals	Fax: **1-888-387-2968**	***Physician/Provider Grievance Form***		Grievance & Appeals Department Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007 Fax: **1-866-387-2968**
Health Care Options	**1-800-430-4263**		8 a.m. - 5 p.m., Mon - Fri	
Medi-Cal for Families Information Line	**1-800-880-5305**		8 a.m. - 8 p.m., Mon - Fri 8 a.m. - 5 p.m., Sat	
Hearing Impaired Services: **California Relay Service**	**711** or Voice to TTY, English: **1-800-735-2922** Spanish: **1-800-855-3000** TTY to voice, English: **1-800-735-2929** Spanish: **1-800-855-3000**		24 hours a day, 7 days a week	For additional information, visit the **California Relay Service** webpage at: **https://ddtp.cpuc.ca.gov**
Interpreter Services	Medi-Cal: **1-800-407-4627** MRMIP: **1-877-687-0549** After hours, use 24/7 NurseLine: **1-800-224-0336** **1-800-368-4424 (TTY)**		8 a.m. - 5 p.m., Mon - Fri	Face-to-face interpreters can be requested via email at: ssp.interpret@wellpoint.com
L.A. Care Member Services	**1-888-839-9909**		7 a.m. - 7 p.m., Mon - Fri	

2 | QUICK REFERENCE

Contact	Outside Los Angeles County	Inside Los Angeles County	Hours of operation (PT)	Address, email, fax and/or website
Long-Term Services and Support	**1-855-871-4899**		8 a.m. - 5 p.m., Mon - Fri	**https://www.aging.ca.gov/Programs/#CBAS** **Fax: 855-336-4041**
Member Eligibility: **Anthem**	Interactive Voice Response (IVR) **1-800-407-4627**	(IVR) **1-888-285-7801**	24 hours a day, 7 days a week	
Member Eligibility: **State of California**	Automated Eligibility Voice System (AEVS): **1-800-456-2387**		24 hours a day, 7 days a week	**https://www.medi-cal.ca.gov/eligibility/login.asp**
24/7 Nurseline	**1-800-224-0336** **1-800-368-4424 (TTY)**		24 hours a day, 7 days a week	Can be used for after-hours member eligibility verification and after-hours requests for interpreter services
ProviderAccess	**https://provider2.anthem.com/wps/portal/ebpmybcc** Log in or follow instructions to create an account.			
Provider Relations (Behavioral Health Providers)	**Contracting:** BHMedi-CalContracting@anthem.com **Network Relations:** BHMedi-CalNetworkRelations@anthem.com			**https://mediproviders.anthem.com/ca**
Secure email: **eBusiness Help Desk**	**1-866-755-2680**		5 a.m. - 5 p.m., Mon - Fri	
TTY	**1-888-757-6034**		8:30 a.m. - 7 p.m., Mon - Fri	
Vision Services: **Vision Service Plan (VSP)**	**1-800-615-1883**		5 a.m. - 8 p.m., Mon - Fri 6 a.m. - 5 p.m., Sat	**www.vsp.com**

COVERED SERVICES GRID

The following table lists benefits covered by the Medi-Cal Managed Care program. This is **not** an all-inclusive list of benefits. For pharmacy benefit information, please see **Chapter 6**. For questions about services not listed, please contact the Customer Care Center or Provider Relations for assistance. Services received from an out-of-network provider without an authorization or referral are not covered, except in the case of medical emergencies.

Benefits and services	Covered by Anthem Blue Cross * Prior authorization (PA) is required.		Covered by DHCS Fee-for-Service (FFS) or other state/county agencies
	PA*		
Abortion		Covered	
Acupuncture		Covered	
Allergy testing • **Antigen**		Covered	
Ambulance services • **Air ambulance** • **Dry runs** • **Ground ambulance** • **Nonemergent transport from home to doctor's office, dialysis or physical therapy**	Yes	Covered	
Amniocentesis		Covered	
Anesthetics (administration)		Covered	
Artificial insemination		Not covered	
Audiology services		**Outside Los Angeles County**: Not covered for members 21 and older except in cases of emergency and where the benefit is required to treat the emergency **Inside Los Angeles County:** Covered	
Behavioral health • **Inpatient behavioral health (covered by FFS Medi-Cal)** • **Outpatient behavioral health (including alcohol and substance use services, crisis intervention and treatment)** • **Professional behavioral health services for mild to moderate level of impairment** • **Professional applied behavioral analysis (ABA) for members under 21 years of age**		Professional services covered; may require preauthorization Note: Marriage and family therapy for relationship problems are not a covered service.	Inpatient and outpatient services administered by the DHCS FFS Program, specifically County Mental Health Departments
Biofeedback		Not covered	

Benefits and services	Covered by Anthem Blue Cross * Prior authorization (PA) is required.		Covered by DHCS Fee-for-Service (FFS) or other state/county agencies
Blood and blood products		Covered	
Cancer screening (refer to Member Handbook)		Covered	
Cataract spectacles and lenses	Yes	Covered when medically necessary	
CHDP – Well Visit - services		Covered	
Chemical dependency rehabilitation			Administered by the DHCS FFS Program, specifically County Mental Health Departments
Chemotherapy drugs		Covered	If under 21 years of age, services covered by California Children's Services
Circumcision		Not covered unless medically necessary	
Colostomy supplies • **Inpatient facility** • **Outpatient dispensing** • **In conjunction with home health**		Covered	
Community-based adult services		Covered	
Dental services (medical) • **Accidental injury — inpatient facility or emergency room** • **Professional component (anesthesia)**		Not covered for members 21 years and older except in cases of emergency and where the benefit is required to treat the emergency Covered if within six months of injury Covered for dental work given in an in-patient facility or surgical center to members who: • Are younger than 7 years of age • Have a developmental (growth) issue and are under 21 years of age • Require benefit due to medical necessity	
Dental services — preventive and restorative		Not covered	Covered by DHCS dental programs, Denti-Cal or dental managed care (county specific)

Benefits and services	Covered by Anthem Blue Cross * Prior authorization (PA) is required.		Covered by DHCS Fee-for-Service (FFS) or other state/county agencies
Detoxification (acute phase)		Not covered	Administered by the DHCS FFS Program, specifically County Mental Health Departments
Diabetic services		Covered for members 21 years of age and older	If under 21 years of age, services covered by California Children's Services
Diagnostic X-ray • **Must use contracted radiology provider**		Covered: • Prior authorization required for selected CT/MRI/MRA/PET/SPECT	
Dialysis		Covered for members 21 years of age and older	If under 21 years of age, services covered by California Children's Services
Directly observed therapy (DOT) for the treatment of tuberculosis		Not covered	Covered by DHCS FFS Program
Durable medical equipment	Yes	Covered except the below: • Items used only for comfort or hygiene • Items used only for exercise • Air conditioners, filters or purifiers • Spas, swimming pools	
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services • **Applies to members under 21 years of age**		Preventive care services are covered including: • Health screenings • Physical exams • Hearing screenings • Vision screenings • Dental screenings • Vaccines • Health education • Blood tests including lead screenings and lipids testing	
Emergency room • **In and outside of California** • **Outpatient facility services** • **Professional**		Covered	
Endoscopic studies		Covered	
Experimental procedures		Not covered	Not covered

Benefits and services	Covered by Anthem Blue Cross * Prior authorization (PA) is required.		Covered by DHCS Fee-for-Service (FFS) or other state/county agencies
Family planning services and supplies (in or out of network)		Covered: • Birth control • Education and counseling • Pregnancy tests • Sexually transmitted disease screening • Sterilization Not covered: • Sterilization reversal • Hysterectomy for sterilization • Fertility treatments	
Fetal monitoring		Covered	
Genetic testing			Covered; administered by the State Genetic Disease Branch
Health education		Covered	
Hearing aids		Covered	
Hemodialysis chronic renal failure		Covered	
Hepatitis B vaccine/gamma globulin		Covered	
Home health care services	Yes	Covered	
Hospice	Yes	Covered	
Hospital based physicians (in lieu of acute inpatient or SNF)		Covered	
Hospitalization • **Inpatient services** • **Outpatient services** • **Intensive care services**		Covered • Private room covered only if medically necessary	
Immunization administration • **Pediatric vaccines** • **Adult vaccines** • **Obstetrical vaccines**		**Pediatric:** Covered under Vaccines For Children (VFC) or CHDP under 22 years of age **Adult:** Covered according to ACIP recommendations Obstetrical: Covered according to ACIP recommendations	
Infant apnea monitor (outpatient)	Yes	Covered	
Infertility diagnosis and treatment		Not covered	
Injectable medications (outpatient and self-administered)		Covered	

Benefits and services	Covered by Anthem Blue Cross * Prior authorization (PA) is required.		Covered by DHCS Fee-for-Service (FFS) or other state/county agencies
Inpatient alcohol and drug abuse			Administered by the DHCS FFS Program, specifically County Mental Health Departments
Interpreter services		Covered	
Lab and pathology services		Covered	
Lithotripsy	Yes	Covered	
Major organ transplants (except kidneys and corneas)			Covered by DHCS FFS Program
Major organ transplants (kidneys and corneas)	Yes	Covered	
Mammography		Covered	
Mastectomy		Covered	
Maternity care • **Pre- and post-natal care** • **Nurse/midwife services** • **Childbirth and cesarean section** • **Newborn exam**		Covered	Alpha fetoprotein (AFP) screening covered by the DHCS FFS Program
Nutritionist/dietician	Yes	Covered	
Obstetrical/gynecological services • **Inpatient facility fees** • **Inpatient professional fees** • **Outpatient professional fee** • **Professional fee** • **Obstetrical CPSP services** • **Vaccines per ACIP recommendations**		Covered	
Office visit supplies including splints, casts, bandages and dressings		Covered	
Ophthalmology services		Covered	
Optometric and optician services		**Outside Los Angeles County:** Not covered for member 21 and older **Inside Los Angeles County**: Covered	
Physical, occupational and speech therapy • **Inpatient or SNF** • **Outpatient** • **Professional**	Yes (for PT only)	Covered	
Physician office visits		Covered	

Benefits and services	Covered by Anthem Blue Cross * Prior authorization (PA) is required.		Covered by DHCS Fee-for-Service (FFS) or other state/county agencies
Podiatry services		Covered if: • Provided by a physician • Outpatient setting • Clinic	
Preadmission testing		Covered	
Prosthetics and orthotics (including artificial limbs and eyes)	Yes	Covered	
Psychology services (psychological testing when clinically indicated to evaluate a mental health condition)	Yes	Covered	
Radiation therapy		Covered	
Radiology services • **Inpatient facility component** • **Outpatient facility component** • **Professional component**	Yes (for some OP svcs.)	Covered	
Reconstructive surgery (not cosmetic)	Yes	Covered	
Rehabilitation services	Yes	Covered	
Routine physical examinations		Covered except when required by job, school, camp or sports program	
Skilled nursing facility (SNF) • **Long-term care limited to month member enters facility plus month following**	Yes	Participating CCI counties — Sacramento and Los Angeles	
Specialist consultations		Covered	
TMJ treatment	Yes	Covered	
Transcranial magnetic stimulation (TMS)		Not covered	
Transfusions (blood and blood products)		Covered	
Transgender services		Covered	
Urgent care center		Covered	
Vision care • **Medically necessary** • **Frames** • **Lenses**		Covered	
Vision screening (refraction)		Covered	

Benefits and services	Covered by Anthem Blue Cross * Prior authorization (PA) is required.		Covered by DHCS Fee-for-Service (FFS) or other state/county agencies
Well Visits – Adults • **Applies to adult members**		Preventive care services are covered including: • Health screenings • Physical exams • Dental screenings • Testing as recommended by the USPSTF • Vaccines per ACIP recommendations • Health education	

2 | QUICK REFERENCE

The following table lists benefits covered by the **Major Risk Medical Insurance Program**. This is **not** an all-inclusive list of benefits. For pharmacy benefit information, please see **Chapter 6**. For questions about services not listed, please contact the Customer Care Center or Provider Relations for assistance. Services received from an out-of-network provider without an authorization or referral are not covered except in the case of medical emergencies.

Major Risk Medical Insurance Program		
Benefits and services	**PA**	**Coverage**
Ambulance		Ground or air ambulance to or from a hospital for medically necessary services
Behavioral health services		Inpatient behavioral health services; limited to 10 days each calendar year
Diagnostic X-ray and lab services		Outpatient diagnostic X-ray and laboratory services
Durable medical equipment and supplies		Must be certified by a physician and required for care of an illness or injury
Emergency health care services		Initial treatment of acute illness or accidental injury; includes hospital, professional services and supplies
Home health care	Yes	Home health services through a home health agency or visiting nurse association
Hospital	Yes	Services provided in an Anthem Blue Cross contracted hospital. Benefits are not covered when provided in a non-contracting hospital within California except in a medical emergency.
Hospice	Yes	Hospice care for members not expected to live more than 12 months if the disease or illness follows its natural course
Infusion therapy	Yes	Therapeutic use of drugs or other substances ordered by a physician and administered by a qualified provider
Physical, occupational and speech therapies		Services of physical, occupational and speech therapists as medically appropriate on an outpatient basis
Pharmacy		Maximum 30-day supply per prescription when filled at a participating pharmacy Maximum 60-day supply for mail order (MRMIP members only)
Physician office visits		Physician services for medical necessity
Pregnancy and maternity care		Inpatient normal delivery and complications of pregnancy Maternity care for a paid surrogate mother who enrolled in the program
Skilled nursing facilities	Yes	Skilled nursing care
Transgender services		Covered
Vision services		MRMIP does not cover vision services (except for vision tests for children)

VERIFYING ELIGIBILITY

Anthem Blue Cross providers are required to verify a person's eligibility and identity before services are rendered at each visit. Providers must ask to see two separate ID cards to verify state Medi-Cal and Anthem Blue Cross eligibility.

Because eligibility can change, **eligibility should be verified at every visit**. Claims submitted for services rendered to a member that is not eligible are **not** reimbursable.

BENEFICIARY IDENTIFICATION CARD

The state of California Department of Health Care Services (DHCS) issues the Beneficiary Identification Card (BIC) after approving the person's Medi-Cal eligibility. The BIC is composed of a nine-character Client Identification Number (CIN), a check digit and a four-digit date that matches the date of issue.

Effective September 12, 2016, DHCS implemented a new BIC card design. New Medi-Cal ID cards will not be replaced all at once**. Providers should accept both BIC designs.**

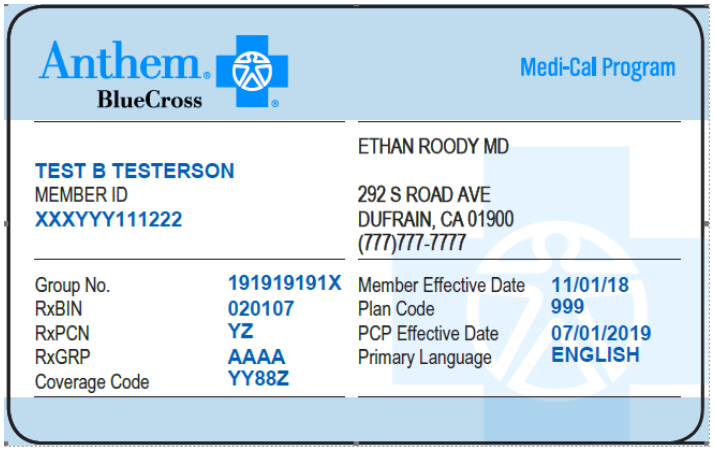
Old BIC Card

New BIC Card

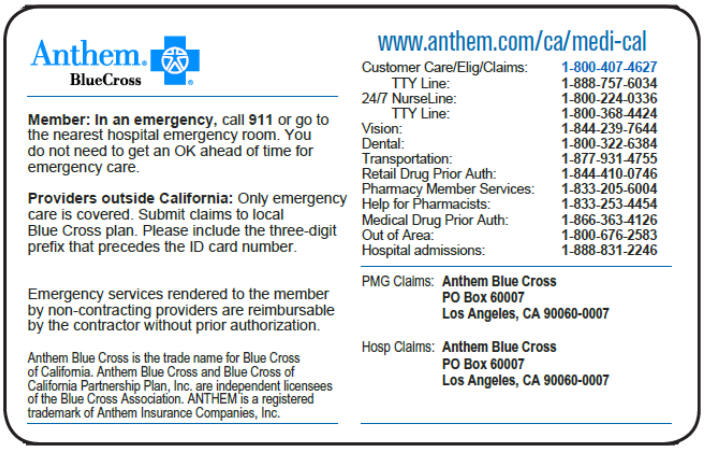
ANTHEM BLUE CROSS MEMBER ID CARDS

Anthem Blue Cross provides members an ID card with plan and provider information on the front and back (sample below).

Front



Back



Note: Los Angeles County members will have a slightly different looking card than non-Los Angeles County members.

Anthem Blue Cross electronically updates member eligibility each day following notification from the DHCS.

MAJOR RISK MEDICAL INSURANCE PROGRAM

There is **no** state of California BIC for the Major Risk Medical Insurance Program (MRMIP) as **MRMIP is not a Medicaid program**. The member will have an Anthem Blue Cross ID card only.

INDIVIDUAL ELIGIBILITY

To verify managed care Medi-Cal member eligibility, choose one of the following four options:

1. Swipe the BIC in a POS device.
2. Use the Automatic Eligibility Verification System (AEVS) by calling:

   ☎ AEVS: **1-800-456-2387**

3. Log on to the Medi-Cal website at:

   https://www.medi-cal.ca.gov/eligibility/login.asp

   - Enter your user ID and password.
   - Select **Submit**, which will take you to the *Real Time Internet Eligibility* page.
   - Enter member information including subscriber ID, birth date, issue date and service date.

4. Log on to the secure Availity website at:

   www.availity.com

From top navigation bar:

- Select **Patient Registration**
- Select **Eligibility and Benefits Inquiry**
- Payer: Anthem-CA
- Enter your National Provider Identifier (NPI)
- Complete Patient Information

  Note: Items with an asterisk (*) are required.

Required information on Availity includes:

- Member ID and the alpha prefix
- Patient Date of Birth **or** Patient First and Last Name
- Date of Service (defaults to current date)
- Selection of defined HIPAA services types
- An active member will show a term date of 12/31/9999

Note: To be HIPAA Version 5010 compliant, providers are no longer able to conduct a name search.

ELIGIBILITY ROSTERS AND CAPITATION REPORTS

Log in to the Anthem Blue Cross ProviderAccess website at:

https://provider2.anthem.com/wps/portal/ebpmybcc

1. Select **Reports** from the top bar
2. The following reports can be obtained:
   - State Sponsored Eligibility Reports – Professional Medical
   - State Sponsored Capitation Reports – Professional Medical

ENROLLMENT/DISENROLLMENT

☎ Medi-Cal Enrollment: **1-800-430-4263**
Hours of operation: Monday to Friday, 7 a.m. - 7 p.m.

☎ MRMIP Enrollment: **1-800-289-6574** or insurance agent/broker
Hours of operation: Monday to Friday, 8:30 a.m. - 5 p.m.

The Medi-Cal managed care enrollment process is managed by Health Care Options (HCO).

Individuals and families whose applications are approved for Medi-Cal receive a pre-enrollment packet that includes a *Medi-Cal Managed Care Enrollment Form* and the plan's provider directory.

Members must return the signed enrollment form within 45 days including selection of a health care plan and a primary care provider (PCP). If the member does not choose a health care plan within the given time frame, the state assigns the member to a Medi-Cal plan.

To learn more about the enrollment process or to obtain the most current forms and information, visit the URL below.

www.healthcareoptions.dhcs.ca.gov/HCOCSP/Home

Additional information is available via the following resources:

California DHCS Medi-Cal website:

www.medi-cal.ca.gov

Health Care Options:

☎ **1-800-430-4263**

STATE AGENCY-INITIATED MEMBER DISENROLLMENT

The DHCS informs Anthem Blue Cross of membership changes by sending daily and monthly enrollment reports. These reports contain all active membership data and incremental changes to eligibility records.

Anthem Blue Cross disenrolls members who are not listed on the monthly full replacement file effective as of the designated disenrollment date. Reasons for disenrollment may include:

- Admission to a long-term care or intermediate care facility beyond the month of admission and the following month
- Change in eligibility status
- County or residence changes
- Health care plan mergers or reorganizations
- Incarceration
- Loss of benefits
- Permanent change of residence out of service area
- Voluntary disenrollments

MEMBER-INITIATED PCP CHANGES

Members have the right to change their PCP monthly or more frequently under certain conditions. When beneficiaries enroll in a Medi-Cal managed care program, they can choose a PCP when selecting their managed care plan. If a beneficiary does not select a PCP when selecting a managed care plan, Anthem Blue Cross will select a PCP for the member.

Members are instructed to call the Anthem Blue Cross Customer Care Center below to request an alternate PCP.

☎ Customer Care Center (outside L.A. County)

☎ **1-800-407-4627**

☎ Customer Care Center (inside L.A. County):
1-888-285-7801
Hours of operation: Monday to Friday, 7 a.m. - 7 p.m.

☎ **1-888-757-6034 (TTY)**

Anthem Blue Cross accommodates member requests for PCP changes whenever possible. Our staff will work with the member to make the new PCP selection, focusing on special needs. Our policy is to maintain continued access to care and continuity of care during the transfer process.

When a member calls to request a PCP change:

- The Customer Care Center (CCC) representative checks the availability of the member's choice. If the member can be assigned to the selected PCP, the CCC representative will do so.
- If the PCP is not available, the CCC representative will assist the member in finding an available PCP.
- If the requested PCP is not available and the member indicates there is an established relationship with the PCP, the CCC will contact the PCP to confirm the member has an established relationship and whether the PCP will accept the assignment.
- If the member advises the CCC that he or she is hospitalized, the CCC will advise the member to call us upon discharge so that we can assist them with their PCP change.
- Anthem Blue Cross notifies PCPs of members' transfers to a new PCP through monthly enrollment reports. PCPs can access these reports by calling our Customer Care Center or by going to our secure ProviderAccess website at:

https://provider2.anthem.com/wps/portal/ebpmybcc

- The effective date of a PCP transfer will be the first day of the following month. Anthem Blue Cross may assign a member retroactively on a case-by-case basis.

MEMBER TRANSFERS TO OTHER PLANS

Members can voluntarily disenroll and choose another health care plan at any time, subject to a restricted disenrollment period.

Approved disenrollments become effective no later than the first day of the second month following the month in which the member files the request. Disenrollment may result in any of the following:

- Enrollment with another health care plan
- Return to traditional or original fee-for-service Medi-Cal for continuity of care if the member's benefits fall into a voluntary aid code

If a member asks a provider how to disenroll from Anthem Blue Cross, the provider should direct the member to call the Customer Care Center in their area:

☎ Medi-Cal Health Care Options (outside L.A. County): **1-800-430-4263**

The member must complete a *Request for Disenrollment Form* and mail it to:

Health Care Options
P.O. Box 989009
West Sacramento, CA 95798-9850

☎ Medi-Cal L.A. Care (Los Angeles County only): **1-888-452-2273**

The member must complete a Plan Partner Change Form and mail it to:

L.A. Care Health Plan
555 West Fifth Street
Los Angeles, CA 90013

MEMBER NONDISCRIMINATION

Anthem Blue Cross does not engage in, aid or perpetuate discrimination against any person by providing significant assistance to any entity or person that discriminates on the basis of race, color or national origin in providing aid, benefits or services to beneficiaries. Anthem Blue Cross does not utilize or administer criteria having the effect of discriminatory practices on the basis of gender or gender identity. Anthem Blue Cross does not select site or facility locations that have the effect of excluding individuals from, denying the benefits of or subjecting them to discrimination on the basis of gender or gender identity. In addition, in compliance with the Age Act, Anthem Blue Cross may not discriminate against any person on the basis of age, or aid or perpetuate age discrimination by providing significant assistance to any agency, organization or person that discriminates on the basis of age. Anthem Blue Cross provides health coverage to our members on a nondiscriminatory basis, according to state and federal law, regardless of gender, gender identity, race, color, age, religion, national origin, physical or mental disability, or type of illness or condition.

Members who contact us with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when an Anthem Blue Cross representative working with a member identifies a potential act of discrimination. The member is advised to submit a verbal or written account of the incident and is assisted in doing so, if the member requests assistance. We document, track and trend all alleged acts of discrimination.

Members are also advised to file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights (OCR):

- Through the OCR complaint portal at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**
- By mail to: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201

- By phone at: **1-800-368-1019 (TTY 1-800-537-7697)**

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

Anthem Blue Cross provides free tools and services to people with disabilities to communicate effectively with us. Anthem Blue Cross also provides free language services to people whose primary language isn't English (for example, qualified interpreters and information written in other languages).These services can be obtained by calling the customer service number on their member ID card.

If you or your patient believe that Anthem Blue Cross has failed to provide these services, or discriminated in any way on the basis of race, color, national origin, age, disability, gender or gender identity, you can file a grievance with our grievance coordinator via:

- Mail: 120 Via Merida, Thousand Oaks, CA 91362
- Phone: **1-805-557-6069**

EQUAL PROGRAM ACCESS ON THE BASIS OF GENDER

Anthem Blue Cross provides individuals with equal access to health programs and activities without discriminating on the basis of gender. Anthem Blue Cross must also treat individuals consistently with their gender identity, and is prohibited from discriminating against any individual or entity on the basis of a relationship with, or association with, a member of a protected class (i.e., race, color, national origin, gender, gender identity, age or disability).

Anthem Blue Cross may not deny or limit health services that are ordinarily or exclusively available to individuals of one gender, to a transgender individual based on the fact that a different gender was assigned at birth, or because the gender identity or gender recorded is different from the one in which health services are ordinarily or exclusively available.

BENEFIT PROGRAMS AND POPULATIONS

MEDI-CAL MANAGED CARE

Medi-Cal Managed Care (Medi-Cal) is a complex network of public and private health care providers who serve California's most vulnerable citizens: low-income California residents who lack health insurance. Medi-Cal pinpoints 165 categories of eligibility but generally covers the following populations:

- Individuals in special treatment programs (including tuberculosis and dialysis)
- Individuals with refugee status
- Low-income children and their parents
- Low-income pregnant women
- Qualified low-income Medicare recipients
- Seniors and persons with disabilities

Anthem Blue Cross provides Medi-Cal services (Medicaid) for the California Department of Health Care Services and the Department of Public Health in the following counties:

- Alameda
- Alpine
- Amador
- Butte
- Calaveras
- Colusa
- Contra Costa
- El Dorado
- Fresno
- Glenn
- Inyo
- Kings
- Los Angeles (in partnership with L.A. Care Health Plan)
- Madera
- Mariposa
- Mono
- Nevada
- Placer
- Plumas
- Sacramento
- San Benito
- San Francisco
- Santa Clara
- Sierra
- Sutter
- Tehama
- Tulare
- Tuolumne
- Yuba

A covered services grid can be found in Chapter 2: Quick Reference. Anthem Blue Cross members enrolled in Medi-Cal Managed Care do not have deductibles or copays.

MAJOR RISK MEDICAL INSURANCE PROGRAM (MRMIP)

The Major Risk Medical Insurance Program (MRMIP) was designed to help insure the very high-risk and those unable to secure private health coverage. The program is defined by the following:

- High-risk insurance pool
- Designed for those unable to secure private health coverage
- Provides 36 months of access to health insurance
- Requires an annual deductible
- Requires copays for covered services

To qualify for MRMIP, applicants must meet the following criteria:

- The applicant must be a California resident.
- Denied individual coverage.

The following table lists all copays, deductibles and maximum benefits provided by the MRMIP.

Copays/limits	Explanation
Calendar year deductible	$500 annual deductible per member $500 annual deductible per household
Copayment	Payable to the provider at the time of service
Yearly maximum copayment	Member's annual maximum copay when using participating providers: $2,500 per member $4,000 per family
Annual benefit maximum	Members must pay for services received after the combined total of all benefits paid under MRMIP reaches $75,000 in a single calendar year

Copays/limits	Explanation
Lifetime benefit maximum	Members must pay for services received after the combined total of all benefits paid under MRMIP reaches $750,000 in the member's lifetime

STATE AND COUNTY-SPONSORED PROGRAMS

To ensure continuity and coordination of care for our members, Anthem Blue Cross enters into agreements with locally-based state and county public health services and programs. Providers are responsible for notifying Utilization Management when a referral is made to any of the agencies or programs listed below.

This notification ensures that case manager nurses and social workers can follow up with members to coordinate care. It also ensures that members receive all necessary services while keeping the provider informed.

- Behavioral Health
- California Children's Services (CCS)
- California Early Start
- Child Health and Disability Prevention Program
- Directly Observed Therapy for Tuberculosis (DOT)
- Family Planning Services
- HIV Counseling and Testing
- Immunization Services
- Women, Infants and Children (WIC)
- Waiver Programs
- Targeted Case Management
- Mental health
- Alcohol and substance use disorder treatment services
- Sexually transmitted diseases

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE

OUTPATIENT (MEDI-CAL)

Behavioral health care services are covered when ordered by a participating provider for the diagnosis and treatment of a behavioral health condition. The conditions covered include the following:

- Treatment for members who have experienced mild to moderate impairment related to a behavioral health diagnosis as identified by DSM-V.

Note: The treatment of **severe mental illness** or **serious emotional disturbance** remains the responsibility of the local county mental health plan.

At Anthem Blue Cross, our behavioral health care benefit is fully integrated with the rest of our health care programs. The provider roles include:

- Ongoing communication and coordination with physical health and other providers
- Encouraging members to consent to the sharing of behavioral health treatment information
- Coordination with treating providers when members are hospitalized
- Ongoing coordination with Anthem Blue Cross Care Management

MEMBER RECORDS AND TREATMENT PLANNING

Comprehensive Assessment

Member records must meet the standards and contain the elements consistent with the licensure of the provider.

Personalized Support and Care Plan

A patient-centered **support and care plan** based on the psychiatric, medical substance use and community functioning assessments found in the initial comprehensive assessment must be completed for any member who receives behavioral health services.

There must be documentation in every case that the member and, as appropriate, his or her family members, caregivers or legal guardian participated in the development and subsequent reviews of the treatment plan.

The support and care plan must be completed within the first 14 days of admission to behavioral health services and updated every 180 days or more frequently as necessary based on the member's progress toward goals or a significant change in psychiatric symptoms, medical condition and/or community functioning.

There must be a signed release of information to provide information to the member's PCP or evidence that the member refused to provide a signature. There must be documentation that referral to appropriate medical or social support professionals have been made.

A provider who discovers a gap in care is responsible to help the member get that gap in care fulfilled, and documentation should reflect the action taken in this regard.

For providers of multiple services, one comprehensive treatment/care/support plan is acceptable as long as at least one goal is written and updated as appropriate for each of the different services that are being provided to the member.

The treatment/support/care plan must contain the following elements:

- Identified problem(s) for which the member is seeking treatment
- Member goals related to each problem(s) identified, written in member-friendly language
- Measurable objectives to address the goals identified
- Target dates for completion of objectives
- Responsible parties for each objective
- Specific measurable action steps to accomplish each objective
- Individualized steps for prevention and/or resolution of crisis, which includes identification of crisis triggers (situations, signs and increased symptoms); active steps or self-help methods to prevent, de-escalate or defuse crisis situations; names and phone numbers of contacts who can assist the member in resolving crisis; and the member's preferred treatment options, to include psychopharmacology, in the event of a mental health crisis
- Actions agreed to be taken when progress toward goals is less than originally planned by the member and provider
- Signatures of the member, as well as family members, caregivers or legal guardian as appropriate

PSYCHOTROPIC MEDICATIONS

Prescribing providers must inform all members considered for prescription of psychotropic or other medications of the benefits, risks and side effects of the medication, alternate medications and other forms of treatment as consistent with their licensure.

TIMELINESS OF DECISIONS ON REQUESTS FOR AUTHORIZATION

- Urgent, preservice requests: within 72 hours of request
- Urgent concurrent requests: within 72 hours of request
- Routine, nonurgent requests: 5 business days and up to 14 calendar days
- Retrospective review requests: within 30 days of request

ACCESS TO CARE STANDARDS

Standards for timely and appropriate access to quality behavioral health care are outlined below:

- Emergent: immediately
- Urgent: within 48 hours of referral/request
- Routine outpatient: within 10 days of request
- Outpatient following discharge from an inpatient hospital: within 7 days of discharge

Definitions

Emergent: Treatment is considered to be an on-demand service and does not require precertification. Members are asked to go directly to emergency rooms for services if they are either unsafe or their conditions are deteriorating.

Urgent: A service need is not emergent and can be met by providing an assessment and services within 48 hours of the initial contact. If the member is pregnant and has substance use problems, she is to be placed in the urgent category.

Routine: A service need is not urgent and can be met by receiving treatment within 10 calendar days of the assessment without resultant deterioration in the individual's functioning or worsening of his or her condition.

HOW TO PROVIDE NOTIFICATION OR REQUEST PREAUTHORIZATION

You may request preauthorization for nonroutine outpatient mental health services that require prior authorization via phone by calling:

☎ **1-888-831-2246** 24 hours a day, seven days a week, 365 days a year

Please be prepared to provide clinical information in support of the request at the time of the call.

You may request preauthorization via fax, email or the provider portal where available for certain levels of care.

Fax forms are located on our website or via email at:

https://mediproviders.anthem.com/ca/pages/forms.aspx

Email: Medi-CalBHUM@wellpoint.com

The fax numbers to use when providing notification or requesting prior authorization for behavioral health services are:

☎ Outpatient requests: **1-888-831-2246**

☎ Inpatient requests: contact the local county department of mental health

Note: All requests for precertification for psychological and neuropsychological testing should be submitted via fax to **1-855-473-7902**. Psychological and neurological testing request forms can also be mailed to:

Behavioral Health Department
Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

BEHAVIORAL HEALTH CLINICAL AUTHORIZATION AND PROTOCOLS

The Anthem Blue Cross clinical authorization process is designed to be flexible, providing primary responsiveness to our members' needs while simultaneously allowing The Anthem Blue Cross clinical team to gather information for appropriate medical necessity determinations.

Authorization of medically necessary services within the required time frames is the responsibility of The Anthem Blue Cross licensed behavioral health clinicians. Whenever a clinician questions the appropriateness of the requested level of care, the review is referred to an appropriate behavioral health care clinician. Our multidisciplinary team of behavioral health care clinicians can include:

- Licensed psychologists
- Licensed professional counselors
- Licensed social workers
- Registered psychiatric nurses
- Board certified psychiatrist

These professionals conduct reviews of behavioral health and substance abuse services to monitor and evaluate treatment requests and progress. They manage utilization, control behavioral health care costs and achieve optimal clinical outcomes through a collaborative approach that considers both utilization review data and nationally recognized clinical practice guidelines to determine the appropriate level of care.

NECESSITY DETERMINATION AND PEER REVIEW

- When a provider requests initial or continued precertification for a covered service, our Utilization Managers obtain

necessary clinical information and review it to determine if the request meets applicable medical necessity criteria.

- If the information submitted does not appear to meet such criteria, the Utilization Manager submits the information for review by the Medical Director or other appropriate practitioner as part of the peer review process.
- The reviewer or the requesting provider may initiate a peer-to-peer conversation to discuss the relevant clinical information with the clinician working with the member.
- If an adverse decision is made by the reviewer without such a peer-to-peer conversation having taken place (as may occur when the provider is unavailable for review), the provider may request such a conversation. In this case, we will make a Medical Director or other appropriate practitioner available to discuss the case with the requesting provider. This conversation may result in the decision being upheld or changed.
- Members, providers and applicable facilities are notified of any adverse decision within notification time frames that are based on the type of care requested and in conformance with regulatory and accreditation requirements.

Professional Billing Requirements

Providers rendering covered behavioral health services should bill Anthem Blue Cross using behavioral health CPT codes. All claims for covered behavioral health services should be billed to Anthem Blue Cross. For more information about proper professional billing procedures, please refer to the Claims chapter of this manual or call the number below:

☎ **1-866-398-1922**

NON-MEDICAL NECESSITY ADVERSE DECISIONS (ADMINISTRATIVE ADVERSE DECISION)

If you received an administrative adverse determination and think that this decision was in error, please see the Grievances and Appeals chapter of this manual for information and instructions on appeals, grievances and payment disputes.

If you did not receive a precertification for a requested service and think that this decision was in error, please see the Grievances and Appeals chapter of this manual for information and instructions on appeals, grievances and payment disputes.

AVOIDING AN ADVERSE DECISION

Most administrative adverse decisions result from non-adherence to or a misunderstanding of utilization management policies. Familiarizing yourself and your staff with notification and precertification policies and acting to meet those policies can eliminate the majority of these decisions. Other administrative adverse decisions result from misinformation about the member's status or benefits.

Adverse decisions of a medical nature are rare. Such adverse decisions usually involve a failure of the clinical information to meet evidenced-based national guidelines. We are committed to working with all providers to ensure that such guidelines are understood and easily identifiable for providers. Peer-to-peer conversations (between a Medical Director and the provider clinicians) are one way to ensure the completeness and accuracy of the clinical information.

Medical record reviews are another way to ensure that clinical information is complete and accurate. Providers who can appropriately respond in a timely fashion to peer-peer and medical record requests are less likely to encounter dissatisfaction with the utilization management process. We are committed to ensuring a process that is quick and easy and will work with participating providers to ensure a mutually satisfying process.

BEHAVIORAL HEALTH CLINICAL PRACTICE GUIDELINES

All providers have access to evidence-based clinical practice guidelines for a variety of behavioral health disorders commonly seen in primary care. These clinical practice guidelines are located online at:

https://mediproviders.anthem.com/ca

CARVED-OUT BEHAVIORAL HEALTH SERVICES

All facility-based behavioral health and substance abuse services are carved out to the local county department of mental health and the county alcohol and other drug programs:

- Inpatient admissions
- Intensive Outpatient Program (IOP)
- Partial Hospitalization Program (PHP)

Behavioral Health Self-Referrals

Members may self-refer to any behavioral health care provider in the Anthem Blue Cross network. If the member is unable or unwilling to access timely services through community providers, call our Customer Care Center for assistance.

BEHAVIORAL HEALTH, ALCOHOL AND OTHER DRUG PROGRAM

The following state and county behavioral health services for those with severe level of impairment are available upon referral:

- 24-hour treatment services
- Case management
- Comprehensive evaluation and assessment
- Group services
- Medication education and management
- Outpatient substance use disorders services
- Pre-crisis and crisis services
- Residential services
- Residential treatment services
- Services for homeless persons
- Vocational rehabilitation
- Wraparound services
- Voluntary inpatient detox

For more detailed information on these programs, go to the state's **Department of Mental Health** website:

www.dhcs.ca.gov/services/Pages/MentalHealthPrograms-Svcs.aspx

INPATIENT

In-patient mental health services are carved out to the local County Mental Health department. Please contact the County Mental Health Department for any questions.

Major Risk Medical Insurance Program (MRMIP)

Services for illnesses that do not meet the criteria for SMI or SED are limited to 15 visits per calendar year.

Inpatient mental health care services include treatment for SMI, which encompasses, but is not limited to, the following:

- Anorexia nervosa
- Bipolar disorder
- Bulimia nervosa
- Major depressive disorders
- Obsessive compulsive disorder
- Panic disorders
- Pervasive developmental disorder or autism
- Schizophrenia
- Schizoaffective disorder

Inpatient mental health care services also include treatment for SED including problems with eating, sleeping, or hurting oneself or others.

Note: For the treatment of SMI or SED, there is no limitation on the number of treatment days.

STATE AND COUNTY SERVICES AND PROGRAMS

The following state and county behavioral health services are available upon referral:

- 24-hour treatment services
- Case management
- Comprehensive evaluation and assessment
- Pre-crisis and crisis services
- Group services
- Medication education and management
- Residential services
- Services for homeless persons
- Vocational rehabilitation

For more detailed information on these programs, go to the state's **Department of Mental Health** website:

www.dhcs.ca.gov/services/Pages/MentalHealthPrograms-Svcs.aspx

COMMUNITY-BASED ADULT SERVICES

Community-Based Adult Services (CBAS) is a facility-based outpatient program serving individuals 18 years of age or older who have functional impairment that puts them at risk for institutional care.

Enrolled members attend an Anthem Blue Cross-contracted adult day health care center several times a week where they can receive (among other services):

- Skilled nursing
- Social services
- Physical, occupational and speech therapies
- Personal care
- Family/caregiver training and support
- Hot meals and nutritional counseling
- Behavioral health services
- Transportation (to/from the center to residence)

The primary objective of CBAS is to prevent inappropriate institutionalization in long-term care facilities. CBAS stresses partnership with the member, the family and/or caregiver, and the PCP in working toward maintaining personal independence.

Each CBAS center has a multidisciplinary team of health professionals who conduct a comprehensive assessment of potential participants and work with the member to meet his or her specific health and social needs.

CBAS ELIGIBILITY AND REFERRAL PROCESS

CBAS services may be provided to members over 18 years of age who:

- Meet nursing facility A or B requirements
- Have organic/acquired or traumatic brain injury and/or chronic mental health conditions
- Have Alzheimer's disease or other dementia
- Have mild cognitive impairment
- Have a developmental disability

Referrals/requests for CBAS can be made by the member, caregiver, family member, nurse practitioner or PCP. A preauthorization is required for all CBAS services. Referrals should be faxed to Anthem Blue Cross at:

- ☎ Los Angeles County: **1-877-279-2482**
- ☎ Santa Clara County: **1-855-336-4041**
- ☎ All other central region counties: **1-855-336-4041**
- ☎ All other northern region counties: **1-855-336-4041**

Once the referral is received, the following steps are taken:

1. An Anthem Blue Cross registered nurse will conduct an eligibility assessment of the

member and assist in locating a CBAS facility if needed.

2. Using an evaluation tool developed and provided by the state, Anthem Blue Cross will approve or deny the request for services.
3. If approved, the member's selected CBAS center will conduct a needs assessment, develop a plan of care for the member, and determine the level of service that will be provided at the center.

For more information on CBAS, call:

☎ California Department of Aging:
1-800-510-2020

For a complete list of CBAS centers and contact numbers, please go to the California Department of Aging website at:

www.aging.ca.gov/ProgramsProviders/ADHC-CBAS

SENSITIVE SERVICES

Members do not need prior authorization and may self-refer for the following sensitive services provided by qualified in-network or out of network providers:

- Family planning services including:
  - Contraceptive pills, devices and supplies
  - Diagnosis and treatment of sexually transmitted disease
  - Health education and counseling
  - Laboratory tests
  - Limited history and physical examinations
  - Pregnancy testing and counseling
  - Sterilization
  - Annual examination with a network obstetrician/gynecologist
  - HIV testing and counseling
  - Sexual assault including rape
  - Drug or alcohol abuse for children 12 years of age or older
  - Outpatient mental health care for children 12 years of age or older who are mature enough to participate intelligently and when either:
    - There is a danger of serious physical or mental harm to the minor or others
    - The children are the alleged victims of incest or child abuse

TELEHEALTH

Telehealth is a health care delivery method that applies high-speed telecommunications systems, computer technology and specialized medical cameras to examine, diagnose, treat and educate patients at a distance.

For example, through a telehealth encounter, a patient at a telehealth clinic in a rural area may seek medical treatment from a provider or specialist in Los Angeles or San Francisco without incurring the expense of traveling to such distant locations.

The advantages of communicating via telehealth are the following:

- Providers can choose from the Anthem Blue Cross network of specialists, no matter where the member lives.
- The member does not have to wait long periods of time to schedule an appointment with a specialist.
- Providers can electronically send the member's medical data to a specialist for review.
- Specialists can use the computers and other equipment to send a recommendation for care back to the providers and members from a distance.

Note: Utilizing telehealth does not require prior authorization.

Telehealth does not include services rendered by audio-only telephone, fax or email communication.

Telehealth can connect a provider's office to a **specialty center** in one of the following ways:

- **Live video consult**: The PCP and specialist meet at the same time using encrypted video conferencing equipment.
- **Store and forward**: PCP sends images of the patient's condition and medical history as an encrypted email to the specialist for review.

Telehealth offers multiple benefits to providers and members:

- The member can continue to be cared for by their local provider.
- The member does not need to travel long distances to receive specialist care.
- The PCP receives all records and test results from the encounter.
- The PCP consults with the specialist participating in the telehealth encounter to design any necessary course of treatment.

Telehealth can also be used for nonclinical consults such as community services, continuing medical education and other provider training sessions.

To find out more about telehealth, use the following contact information:

☎ If you are located in Los Angeles, please call: **1-866-465-2272**

☎ If you are located in central California and surrounding rural counties, please call: **1-877-811-3113**

☎ If you located in northern California and surrounding rural counties, please call: **1-888-252-6331**

☎ For contracting questions, please call Provider Solutions at: **1-877-496-0045**

TRANSPORTATION

NON-EMERGENCY MEDICAL TRANSPORTATION

Non-emergency medical transportation (NEMT), which may require prior authorization, allows members to be transported to medical appointments for covered services, transferred from a hospital to another hospital, facility or home. It is a covered service when **all** of the following criteria have been met:

- Medical necessity
- An Anthem Blue Cross provider requests the service
- The member is not able to use a bus, taxi, car or van to get to their appointment
- It is approved in advance by Anthem Blue Cross (when required)

LogistiCare will help Anthem Blue Cross members manage their rides to and from medically necessary medical appointments including rides by livery, ambulette or mass transit.

Routine transportation is an Anthem Blue Cross value-added benefit, so there is no additional cost for this service to these members.

☎ Members can call **1-877-931-4755** to arrange for transportation through LogistiCare.

EMERGENT TRANSPORTATION — AMBULANCE SERVICES

Ambulance services must come from a licensed ambulance or air ambulance company and be used only for emergencies. Coverage includes:

- Base charge and mileage
- Cardiac defibrillation
- CPR
- EKGs
- IV solutions
- Monitoring
- Oxygen
- Supplies

☎ Customer Care Center (outside L.A. County): **1-800-407-4627**
Hours of operation: Monday to Friday, 7 a.m. - 7 p.m.

☎ Customer Care Center (inside L.A. County): **1-888-285-7801**
Hours of operation: Monday to Friday, 7 a.m. - 7 p.m.

☎ MRMIP Customer Care Center: **1-877-687-0549**
Hours of operation: Monday to Friday, 8:30 a.m. - 5 p.m.

24/7 NURSELINE

Questions about health care prevention and management don't always come up during office hours. 24/7 NurseLine is a 24-hour-a-day, 7-day-a-week phone line staffed by registered nurses.

24/7 NurseLine allows members to closely monitor and manage their own health by giving them the ability to ask questions whenever they come up.

☎ 24/7 NurseLine: **1-800-224-0336**

☎ TTY: **1-800-368-4424**

Members can call 24/7 NurseLine for:

- Self-care information including assistance with symptoms, medications and side-effects, and reliable self-care home treatments
- Access to specialized nurses trained to discuss health issues specific to our teenage members
- Information on more than 630 health care topics through the 24/7 NurseLine audio tape library
- Assistance in finding an in-network provider

Members can also call our 24/7 NurseLine anytime to speak to a registered nurse. Nurses provide health information and options for any of the following:

- Emergency instructions
- Health concerns
- Local health care services
- Medical conditions
- Prescription drugs
- Access to interpreter services

WELLNESS PROGRAMS

https://mss.anthem.com/ca/pages/health-wellness.aspx

Anthem Blue Cross health services programs are designed to improve our members' overall health and well-being by informing, educating and encouraging self-care in the early detection and treatment of existing conditions and chronic disease.

These targeted programs are designed to supplement providers' treatment plans and include multiple categories such as:

- **Preventive Care Programs** for all members including the Initial Health Assessment, the Staying Healthy Assessment (SHA) Tool and Well Woman programs and vaccines when recommended by the ACIP
- **Wellness Programs** that promote knowledge on self-care for targeted medical conditions and chronic disease
- **Health Education** including the **24/7 NurseLine** for all health-related questions
- **Emergency Room Initiative** that instructs members on the proper use of emergency room services

We introduce new members to these programs through a new member packet, which includes preventive health care guidelines and a *Member Services Guide* that includes information on how to access health education services.

After that, we utilize a variety of methods and informal settings to inform our members about available health services including:

- Direct mailings
- Health education classes
- Telephone calls
- Health fairs and community events

TOBACCO CESSATION PROGRAMS

Anthem Blue Cross supports smoking cessation for members who want to become smoke-free by:

- Assisting members in improving their health status and quality of life by becoming more actively involved in their own care.
- Encouraging members to quit using tobacco.
- Supporting members' tobacco cessation efforts with resources, referral programs and education.

Tobacco cessation/information available to members:

- **California Smokers' Helpline** offers free telephonic counseling, self-help materials and online help in six languages.

☎ California Smokers' Helpline: **1-800-662-8887 (1-800-NO-BUTTS)**

www.nobutts.org

American Lung Association Freedom from Smoking offers telephonic counseling, in-person group clinics and online resources.

☎ **www.lung.org/stop-smoking/join-freedom-from-smoking**

Note: Enrollment in tobacco counseling **is not required** in order to obtain tobacco cessation materials.

Provider Assessment of Tobacco Use:
PCPs and their qualified staff need to implement the tobacco cessation interventions as outlined in the revised *MMCD Policy Letter 16-014* dated November 30, 2016, from the California Department of Health Care Services.

These interventions include conducting initial and annual assessments of all members of any age who use tobacco products or are exposed to tobacco smoke and document this information in the member's medical record. This can be accomplished through instituting a tobacco user identification system per USPSTF recommendations:

- Using the Staying Healthy Assessment or other IHEBA.
- Adding tobacco use as a vital sign in the chart or electronic health records or by use of the ICD-10 codes in the medical record to record tobacco use.
- Placing a chart stamp or sticker on the chart when the beneficiary indicates he/she uses tobacco.
- A recording on the Child Health and Disability Prevention Program Confidential Screening/Billing Report (PM160).
- Prescribing Food and Drug Administration (FDA) approved tobacco cessation medications to non-pregnant adults of any age.

Note: Medi-Cal plans shall cover all FDA-approved tobacco cessation medications for adults who use tobacco products. This includes over-the-counter medications with a prescription from the provider.

A full set of ICD-10 codes to record tobacco use can be found at:

http://www.ctri.wisc.edu/documents/icd10.pdf

Anthem Blue Cross covers the following **without prior authorization**:

- Nicotine patches
- Nicotine gum
- Nicotine lozenges
- Bupropion SR (Zyban)

Anthem Blue Cross covers the following **with prior authorization**:

- Nicotine nasal spray
- Nicotine inhaler
- Varenicline (Chantix)
- Referring tobacco users of any age to available individual, group and telephone counseling. Anthem Blue Cross members qualify for four counseling sessions of at least ten minutes for at least two separate quit attempts each year without prior authorization.

Providers can:

- Use the 5A's Model or other validated behavior change model when counseling members.
- Refer a member to the **CA Smoker's Helpline** at **1-800-NO-BUTTS** or another equivalent line.
- Refer to available community programs.
- Ask all pregnant women if they use tobacco or are exposed to tobacco smoke. If they smoke, offer at least one face-to-face counseling session per quit attempt and refer to a tobacco cessation quit line. Counseling services will be covered for 60 days after delivery. Smoking cessation medications are not recommended during pregnancy.
- Provide education including brief counseling to children and adolescents to prevent initiation of tobacco in school-aged children and adolescents.

Anthem Blue Cross will monitor provider performance in implementing these tobacco cessation interventions through various processes comprising of medical record review, facility site review process, and review of medical or pharmacy claims data.

Providers can read the policy letter by going to the DHCS website at:

www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-014.pdf

The Smoking Cessation Leadership Center is a national program that collaborates with health professionals and institutions to increase their competency in helping smokers quit. They provide various types of resources including curriculums, presentations, online training, publications, toolkits and webinars for continuing education.

If you are interested in tobacco cessation updates through the aforementioned outlets, please visit:

http://smokingcessationleadership.ucsf.edu

For additional information and provider training resources, visit The Anthem Blue Cross tobacco cessation webpage at:

https://mediproviders.anthem.com/ca/pages/tobacco-cessation.aspx

EMERGENCY ROOM ACTION CAMPAIGN

The Anthem Blue Cross **ER Action Campaign** identifies members who visit the emergency room for non-emergency services that can be better managed at their doctor's office or an urgent care center.

With this campaign, we can help patients know that non-emergency, preventive and follow-up care should always start with their doctor.

The ER Action Campaign teaches members about:

- Seeking care for non-emergency events
- Contacting their doctor first before going to the ER
- Alternatives to ER use
- Importance of follow-up care by their PCPs

Our ER Action Campaign relies on the support of providers like you, who remind patients that their doctor's office and our 24/7 NurseLine should be their first call for non-emergency conditions.

Working together, we can help your patients get appropriate care and avoid the long wait times and high costs often associated with ER visits and encourage a strong relationship with you, their primary doctor.

HEALTH EDUCATION NO-COST CLASSES

https://mediproviders.anthem.com/ca/pages/health-education-programs.aspx

Anthem Blue Cross offers health education services and programs to meet the specific health needs of our members, promote healthy lifestyles, and improve the health of those living with chronic diseases.

Health education classes take place at hospitals and/or community-based organizations. Classes are available at no charge to the member and are available upon self-referral or referral by Anthem Blue Cross providers.

Classes vary from county to county and include the following topics:

- Asthma management
- Breastfeeding education
- Diabetes management
- Exercise
- Family planning
- HIV/STD control
- Hypertension/heart disease education
- Injury prevention
- Nutrition
- Obesity
- Parenting
- Perinatal education
- Smoking cessation/tobacco prevention
- Substance use

Members receive information about health education classes through enrollment materials, member website, and information made available at their provider's office.

HEALTH EDUCATION REFERRAL

Providers can refer members to health education classes using the ***Health Education & Cultural and Linguistic Referral Form*** on our provider website.

The form is located within the health education site at:

https://mediproviders.anthem.com/ca/pages/health-education-programs.aspx

To schedule a health education class, members should call our Customer Care Centers.

If the member receives one-on-one counseling from an Anthem Blue Cross Health Educator, Anthem Blue Cross sends a confirmation letter to the member's PCP with the following information:

- Member's name
- Member's ID number
- Topic discussed

If the provider administers health education to the member, it must be documented in the member's medical record. Documentation must include the following:

- Education topic
- Identification of person providing the education
- Materials distributed to the member
- Notation of any follow-up or recommendations

If a member is referred for one-on-one health education counseling and the Health Educator is unable to reach him/her after multiple attempts, Anthem Blue Cross sends an *Unable to Reach* letter to the member's PCP.

Similarly, if the referred member declines health education counseling, Anthem Blue Cross will send a letter notifying the provider.

DIABETES PREVENTION PROGRAM

Medi-Cal Managed Care (Medi-Cal) members at risk for type 2 diabetes have access to the Centers for Disease Control and Prevention (CDC) Diabetes

Prevention Program (DPP) through a new member benefit. DPP has been proven by the National Institute of Health (NIH) in a randomized controlled trial to greatly reduce the progression of prediabetes to type 2 diabetes. Services are delivered by trained lifestyle coaches and organizations recognized by the CDC at no cost to the member.

The DPP is a year-long program that consists of weekly sessions with a lifestyle coach for the first six months and monthly maintenance sessions for the latter six months. Sessions can be held in a group classroom setting or online. Participants will learn realistic lifestyle changes emphasizing weight loss through exercise, healthy eating and behavior modification.

Member eligibility criteria include:

- At least 18 years of age
- BMI of 25 or greater
    - If member is of Asian descent, a BMI of 23 or greater is required.
- Blood screening (optional, if available):
    - Hemoglobin A1C: 5.7% to 6.4%
    - Fasting plasma glucose: 100 to 125 mg/dL
    - Oral Glucose Tolerance Test: 140 to 199 mg/dL
- **Exclusions** include no previous diagnosis of end-stage renal disease or type 1 or type 2 diabetes; not pregnant (*previous gestational diabetes is not an exclusion)*

Providers can refer members to the DPP by completing the DPP Provider Referral Form located at:

https://mediproviders.anthem.com/ca/pages/forms.aspx

Providers can also direct members to take the online risk assessment by visiting

https://solera4me.com/AnthemBC_MediCal

or by calling **1-833-516-4483** to determine eligibility and enroll in the DPP.

HEALTH EDUCATION MATERIALS FOR YOUR OFFICE

Health education materials including health topic-specific brochures such as Diabetes, Asthma, Smoking, Pregnancy and Baby's Health, Exercise, and Nutrition can be found on the Anthem Blue Cross **provider website** at the beginning of this section.

Under *Provider Support*, you will also find links to other valuable resources such as cultural and linguistic tools, perinatal education brochures, and information regarding breastfeeding promotion. All of these resources may be downloaded. You may also request hard copies of these materials by calling the appropriate Customer Care Center at the number(s) listed at the beginning of this chapter.

CULTURAL AND LINGUISTIC/ INTERPRETER SERVICES

At Anthem Blue Cross, we recognize that providing health care services to a diverse population can present challenges. We know it is important to continually increase your knowledge of, and ability to support, the values, beliefs, and needs of diverse patients. Differences in our members' ability to read may add an extra dimension of difficulty when providers try to encourage follow-through on treatment plans.

Sometimes the solution is as simple as finding the right interpreter for an office visit. Other times, a greater level of cultural awareness, like the examples, below can open the door to the kind of interaction that makes treatment plans most effective.

- Has the patient been raised in a culture that frowns upon direct eye contact or receiving medical treatment from a member of the opposite sex?
- Is the patient self-conscious about his or her ability to read instructions?

Our **Cultural Diversity and Linguistic Services Toolkit** called *Caring for Diverse Populations* was developed to give you specific tools for breaking through cultural and language barriers in an effort

to better communicate with your patients. The toolkit can be downloaded by selecting the link below:

https://mediproviders.anthem.com/ca/pages/manuals-training-more.aspx

This toolkit gives you the information you'll need to continue building trust. It will enhance your ability to communicate with ease, talking to a wide range of people about a variety of culturally sensitive topics. And it offers cultural and linguistic training to your office staff so that all aspects of an office visit can go smoothly.

The toolkit contents are organized into the following sections:

- Improving communications with a diverse patient base
  - Encounter tips for providers and their clinical staff
  - A memory aid to assist with patient interviews
  - Help in identifying literacy problems
- Tools and training for your office in caring for a diverse patient base
  - Interview guide for hiring clinical staff who have an awareness of cultural competency issues
  - Americans with Disabilities Act (ADA) requirements
- Resources to communicate across language barriers
  - Tips for locating and working with interpreters
  - Common signs and common sentences in many languages
  - Language identification flashcards
  - Language skill self-assessment tools
- Resources to increase awareness on how cultural background impacts health care delivery
  - Tips for talking with people across cultures about a variety of culturally sensitive topics
  - Information about health care beliefs of different cultural backgrounds
- Regulations and standards for cultural and linguistic services
  - Identifies important legislation impacting cultural and linguistic services including a summary of the **Culturally and Linguistically Appropriate Services (CLAS) standards**, which serve as a guide on how to meet these requirements
- Resources for cultural and linguistic services
  - Cultural competency web-based resources

The toolkit contains materials developed by and used with the permission of the Industry Collaboration Effort (ICE) Cultural and Linguistic Workgroup, a volunteer, multidisciplinary team of providers, health plans, associations, state and federal agencies, and accrediting bodies working collaboratively to improve health care regulatory compliance through public education.

www.iceforhealth.org

In addition to the caring for diverse populations toolkit, Anthem offers additional resources to support provision of culturally and linguistically appropriate services, including **My Diverse Patients** and a **Cultural Competency Training**, which can be accessed at:

https://mediproviders.anthem.com/ca/Pages/home.aspx > Manuals, Directories, Training & More > Resources.

My Diverse Patients is a resource-rich, care provider website that covers topics relevant to providing culturally competent care and services for diverse individuals. The cultural competency

training offers information on key components to the provision of culturally competent care.

LANGUAGE CAPABILITY OF PROVIDERS AND OFFICE STAFF

Anthem Blue Cross strives to have a provider network that can meet the linguistic needs of our members. An important component of that is having network providers that are aware of the language capabilities of themselves and their office staff.

Providers must notify members of the availability of interpreter services and strongly discourage the use of friends and family members, especially children, acting as interpreters. Under the Federal guidance, published as section 1557 of the *Affordable Care Act,* providers are required to utilize qualified interpreters while interacting with members with limited English proficiency.

As defined in Section 1557, a "qualified interpreter" for an individual with limited English proficiency means an interpreter who via a remote interpreting service or an onsite appearance. It requires that a qualified interpreter:

1. Adheres to generally accepted interpreter ethics principles including client confidentiality.
2. Has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language.
3. Is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology, and phraseology.

Multilingual staff should self-assess their non-English language speaking and understanding skills prior to interpreting on the job.

Please be sure to provide annual updates on the language capabilities of your office staff and at least every three years for yourself by downloading the *Provider Change Form* by selecting the link below:

https://www11.anthem.com/ca/provider/f3/s1/t0/pw_b144192.pdf

This information will be reported in the *Provider Directory* to help members find a provider and/or office staff that speaks their preferred language.

INTERPRETER SERVICES

Providers must notify members of the availability of interpreter services and strongly discourage the use of friends and family, particularly minors, to act as interpreters. It is important that you or your office staff document the member's language, any refusal of interpreter services and requests to use a family member or friend as an interpreter in the member's medical record.

Face-to-face interpreters for members needing language assistance including **American Sign Language** are available **at no cost** to the provider or member by placing a request at least 72 hours in advance. A 24-hour cancelation notice is required.

Over-the-phone interpreters are available 24 hours a day, 7 days a week.

To obtain free interpreting services, please call our Customer Care centers.

☎ For after-hours telephone interpreter services, call the 24/7 NurseLine at **1-800-224-0336**

☎ TTY: **1-800-368-4424** and take the following steps.

1. Give the customer care associate the member's ID number.
2. Explain the need for an interpreter and state the language.
3. Wait on the line while the connection is made.
4. Once connected to the interpreter, the associate or 24/7 NurseLine nurse introduces the Medi-Cal member, explains

the reason for the call and begins the dialogue.

Request/Refusal of Interpreter Services forms are available in threshold languages on the **Free Interpreting Services** website below:

https://mediproviders.anthem.com/ca/pages/free-interpreting-services.aspx

HEARING LOSS, VISUAL AND/OR SPEECH IMPAIRMENT SERVICES

During business hours, members with hearing loss or speech impairment can call the following numbers:

- ☎ Voice to TTY (English): **711** or **1-800-735-2922**
- ☎ Voice to TTY (Spanish): **1-800-855-3000**
- ☎ TTY to Voice (English): **1-800-735-2929**
- ☎ TTY to Voice (Spanish): **1-800-855-3000**
- ☎ After regular business hours, members can call the 24/7 NurseLine TTY number: **1-800-368-4424**

For additional information, visit the California Relay Service webpage at:

http://ddtp.cpuc.ca.gov/default1.aspx?id=1482

Members with visual impairments can request verbal assistance or alternative formats for assistance with printed materials at no cost to the member.

TRANSLATION OF MATERIALS

Members can request translation of materials into non-English languages and alternative formats at no cost to them by contacting the designated Customer Call Center number in **Chapter 2: Contact Information**.

CULTURAL AND/OR LINGUISTIC REFERRAL

Providers can make a cultural and /or linguistic referral using the ***Health Education & Cultural and Linguistic Referral Form*** on our provider website.

The form is located within the health education site at:

https://mediproviders.anthem.com/ca/pages/health-education-programs.aspx

MEMBER RIGHTS AND RESPONSIBILITIES

The members of The Anthem Blue Cross two health care programs, Medi-Cal and the Major Risk Medical Insurance Program, should be clearly informed about their rights and responsibilities in order to make the best health care decisions. That includes the right to ask questions about the way we conduct business as well as the responsibility to learn about their health care plan.

Members have certain rights and responsibilities when receiving their health care. They also have a responsibility to take an active role in their care.

As their health care partner, we are committed to making sure their rights are respected while we provide their health benefits. This also means giving them access to our network providers and the information they need to make the best decisions for their health and welfare.

The following are our members' rights and responsibilities as stated in each of the member handbooks. They are also posted on our website at:

https://mss.anthem.com/Documents/CACA_CAID_MC_MemberHandbook_ENG.pdf

ADVANCE DIRECTIVES

Anthem Blue Cross recognizes a person's right to dignity and privacy. Our members have the right to execute an **advance directive**, also known as a living will, to identify their wishes concerning health care services in the event that they become incapacitated. Providers may be asked to assist members in procuring and completing the necessary forms.

Advance directive documents should be on hand in the event a member requests this information. Members, over the age of 18 years, will be asked by the provider if they are aware of advance

directives or want more information. This information will be documented in the chart.

MEDI-CAL

Our members have the right to:

- Be treated with respect, giving due consideration to the member's right to privacy and the need to maintain confidentiality of the member's medical information.
- Have access to, and where legally appropriate, receive copies of, amend or correct their medical record.
- Be free to exercise these rights without adversely affecting how they are treated by Contractor, providers, or the State.
- Receive information about the health plan, its services, its practitioners and providers and member rights and responsibilities
- Receive written information in alternative formats (including audio CD, large print and braille) at no cost to them upon request and in a timely way that is correct for the format that they asked for.
- Obtain member materials in a language other than English at no cost to them.
- Receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition and ability to understand, regardless of cost or benefit coverage.
- Expect us to keep private their personal health information. This is as long as it follows state and federal laws and our privacy policies.
- Be free of any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Choose their PCP.
- Refuse care or treatment from their PCP or other caregivers.
- Work with their doctors in making choices about their health care.
- Do what they think is best for their health care without anyone stopping them. They may make health decisions without fear of retaliation from their doctor or health plan.
- Make an advance directive (also known as a living will).
- Get a range of covered services.
- Get family planning services.
- Be treated for STIs.
- Access minor consent services if they are under 18 years of age.
- Obtain emergency care outside of the Anthem Blue Cross network as federal law allows.
- Have access to family planning services, Federally Qualified Health Centers, American Indian Health Programs, sexually transmitted disease services and emergency services outside the contractor's network pursuant to the federal law.
- To receive oral interpretation services for their language at no cost to them.
- Tell us how they would like to change this health plan, including changes to the member's rights and responsibilities.
- To voice grievances or appeals, either verbally or in writing, about the organization or the care received.
- To participate in decision making regarding their own health care including the right to refuse treatment. Ask the Department of Social Services for a state fair hearing.
- Ask the Department of Managed Health Care for an independent medical review.
- Choose to leave this health plan.

Members have the responsibility to:

- Give us, their doctors and other health care providers the information needed (to the best of their ability) to help them get the best possible care and all other benefits they are entitled to.

- Understand their health problems as well as they can and work with their doctors or other health care providers to make a treatment plan they all agree on.
- Follow the care plan that they have agreed on with their doctor and other health care providers.
- Follow their doctor's advice about taking good care of their selves.
- Use the right sources of care.
- Bring their health plan ID card with them when they visit their doctor.
- Treat their doctors and other caregivers with respect.
- Understand their health plan.
- Know and follow the rules of their health plan.
- Know that laws govern their health plan and the types of service they get.
- Know we cannot discriminate against them because of their age, sex, race, national origin, culture, language needs, sexual orientation or health.

MAJOR RISK MEDICAL INSURANCE PROGRAM (MRMIP)

As an Anthem Blue Cross member, members have the right to:

- Be informed of their rights and responsibilities.
- Receive information about Anthem Blue Cross services, doctors and specialists.
- Receive information about all their other health care providers.
- Talk honestly with their doctors about all the appropriate treatments for their condition, no matter what the cost or whether their benefits cover them.
- Use interpreters who are not their family members or friends (interpreters will be provided at no charge to them).
- Be treated with respect and with regard for their dignity in all situations.
- Have their privacy protected by Anthem Blue Cross, their doctors and all their other health care providers.
- Know that information about them is kept confidential and used only to treat them.
- Be in charge of their health care.
- Be actively involved in making decisions about their health care.
- Make an advance directive.
- Suggest changes in their health plan.
- Complain about Anthem Blue Cross or the health care they receive.
- File a complaint or grievance if their cultural and linguistic needs are not met.
- Appeal a decision from Anthem Blue Cross about the health care they receive.
- Make recommendations about our Rights and Responsibilities Policy.

Members have the responsibility to:

- Give Anthem Blue Cross, their doctors and other health care providers the information needed to treat them to the best of their ability.
- Understand their condition and help their doctor set treatment goals you both agree on to the best of their ability.
- Follow the plans they have agreed on with their doctors and their other health care providers.
- Follow the guidelines for healthy living their doctor and their other health care providers suggest.
- Use the emergency room only in cases of emergency or as directed by their provider.

COVERAGE AND LIMITATIONS

ELIGIBILITY

Prescription drugs without a copay or deductible are a covered Medi-Cal benefit if the following conditions are met:

- The drug is prescribed by an appropriate and licensed clinician.
- The drug is used for the care and treatment of an injury or illness.
- The drug is pre-approved by Anthem Blue Cross when it is not included on the Preferred Drug List (PDL).
- The drug is approved for human use by the Food and Drug Administration (FDA).

PHARMACY NETWORK

Members must have their prescriptions filled by drugstores within the Anthem Blue Cross pharmacy network. Our pharmacy network provides coverage in California and its bordering states: Arizona, Nevada and Oregon.

Our Provider Directory lists drugstores that are in the Anthem Blue Cross pharmacy network.

Prescriptions can be filled at more than 3,000 retail pharmacies in California and a listing of these can be found in our Provider Directory.

☎ To verify pharmacy network participation or Anthem Blue Cross drug coverage, please call: **1-800-700-2533**.

PHARMACY MEMBER COST SHARING

Anthem Blue Cross members enrolled in Medi-Cal do not have a copay nor deductible for covered prescription drugs. See applicable sections regarding cost-sharing for the Major Risk Medical Insurance Program (MRMIP) prescription benefit.

MEDI-CAL PHARMACY BENEFIT

Anthem Blue Cross covers a maximum 30-day supply. Providers may issue refills on the initial prescription. Prescription refills will be allowed after 90% of the previous prescription's supply has been utilized according to the prescription directions.

MRMIP PHARMACY BENEFIT

Prescription drugs are a MRMIP covered benefit. Coverage guidelines are as follows:

- $5 copay for generic drugs; limited to a 30-day supply
- $5 copay for generic drugs; limited to a 60-day supply through IngenioRx Mail Service Pharmacy, the Anthem Blue Cross mail order pharmacy
- $15 copay for brand name drugs; limited to a 30-day supply
- $15 copay for brand name drugs; limited to a 60-day supply through IngenioRx Mail Service Pharmacy, the Anthem Blue Cross mail order pharmacy

MRMIP benefits include but are not limited to the following drug categories:

- Contraceptive drugs
- Drugs for smoking cessation
- Formulas and special food products for treatment of phenylketonuria (PKU)
- Glucagon
- Insulin and insulin syringes
- Prescription prenatal vitamins
- Prescription fluoride supplements

PHARMACY BENEFIT EXCLUSIONS

The following medications are not covered by the pharmacy benefit:

- Non-CMS OBRA rebateable drugs unless indicated by the state
- Medications used for cosmetic reasons (including hair growth)
- Medications used for infertility
- Medications used for weight loss
- Drugs used for erectile dysfunction or sexual enhancement
- Drugs not approved by the FDA
- DESI drugs
- Unit-dose (UD) and repackaged drugs
- Experimental or investigational drugs
- Dietary supplements (except PKU treatments)
- Dietary supplements (except PKU treatments

QUANTITY LIMITS

Certain medications are subject to quantity limits. A quantity limit establishes the maximum amount of medication that is covered within a defined period of time.

Generally, the quantity limits are established based upon manufacturer or FDA dosing recommendations. If a member has a medical condition that requires exceeding the limit, a prior authorization request containing documentation of medical need for consideration will be required.

DOSE CONSOLIDATION

Similar to quantity limits, certain medications may be subject to dose consolidation requirements. This program works with the member, the member's physician or health care provider, and the pharmacist to replace multiple doses of lower strength medications where clinically appropriate with a single dose of a higher-strength medication (only with the prescribing physician's approval).

Prior to dispensing of multiple doses of the lower strength medications, a written prior authorization needs to be submitted for an internal review by Anthem Blue Cross to determine medical necessity.

OUT OF AREA PHARMACY SERVICES

Anthem Blue Cross provides a maximum of 30 days of continuous out-of-service area coverage for prescription drugs. If the member will be out of their service area for longer than 30 days, the prescribing physician must submit a prior authorization request. The member will be referred to the health plan for eligibility review. If out-of-service coverage is not approved, the member will have to pay out of pocket for the prescription and submit a Prescription Reimbursement Claim Form for reimbursement consideration if they fill a prescription outside of their network. Anthem Blue Cross does not cover pharmacy services outside of the United States.

Note: If the member cannot find a pharmacy that participates with the company, the member may pay for the medication and submit a reimbursement request.

GENERIC MEDICATIONS

The Anthem Blue Cross pharmacy benefit has a mandatory generic program. The appropriate use of generic drugs is one method of providing cost-effective drug therapy. Multi-source brand name drugs are not covered and substitution of a generic is required when an FDA-approved generic equivalent exists.

This Multi-Source Brand Prior Authorization program promotes the utilization of appropriate generic alternatives as first-line therapies when medically appropriate.

Prior to prescribing any multi-source brand, prescribers are encouraged to consider using its preferred generic alternative. Brands with a generic alternative will require a written prior authorization and an internal review by Anthem Blue Cross to determine medical necessity for benefit coverage.

MAIL ORDER PHARMACY

Anthem Blue Cross does not offer a mail order benefit for Medi-Cal. Review the first page of this chapter for pharmacy mail order information on MRMIP prescription benefits.

PHARMACY BENEFIT CARVEOUTS

The following medications are administered by the state and reimbursed by fee-for-service (FFS) Medi-Cal:

- Antipsychotic, mood stabilizer and associated medications
- Erectile dysfunction drugs
- Opiate and alcohol dependence treatment drugs
- HIV drugs
- Antihemophilic blood factors

OVER-THE-COUNTER DRUG PHARMACY BENEFIT

Anthem Blue Cross follows the fee-for-service Medi-Cal over-the-counter (OTC) drug list. The FFS OTC drug list is available online on the California Medi-Cal Pharmacy webpage.

PREFERRED DRUG LIST

The Anthem Blue Cross Preferred Drug List (PDL) lists the preferred and/or nonpreferred drugs within the most commonly prescribed therapeutic categories, identifying pharmaceutical preferences based upon cost, value and evidence-based outcomes for member care.

All FDA-approved medications are eligible for coverage unless specified otherwise. The PDL identifies the preferred prescription medication and may include select OTC medications where applicable.

OTC medications are generally less costly than prescription alternatives. Their use can contribute to cost-effective therapy and are recommended as first-line agents when appropriate. Medications that are not preferred and are not statutory benefit exclusions may be considered for coverage by means of the prior authorization process.

The PDL is posted on the website for members and providers. It is also made available in hard copy upon request. The PDL is updated periodically but at a minimum quarterly. These changes are posted to the website upon their effective date and are faxed to participating providers.

To request a drug be added to the PDL, please contact Anthem Blue Cross through the website below:

https://www11.anthem.com/ca/forms/pharmacy/formulary_addition.html

PHARMACY RESTRICTION PROGRAM

The Anthem Blue Cross Pharmacy Restriction process limits members to a single pharmacy to obtain their medications. The need for restriction is determined as a result of medication claims review.

Members identified with uncoordinated care, excessive utilization or suspected patterns of fraud and abuse may also be referred to Case Management.

Using predefined queries, the Pharmacy department identifies members that may meet the criteria for lock-in. Case managers review the clinical history of the member as well as attempt to contact the member for additional information.

After review with health plan medical directors the decision for lock-in is made. At the same time, any recommendations for care coordination or case management become part of a total care plan for the member. The members are notified in advance of the lock-in and provided 30 days to appeal or request additional information.

All providers that have prescribed for this member in the previous 90 days will be notified of the member's lock-in status as well as receive a six-month profile regarding the member's utilization.

The network pharmacy provider will also receive a letter identifying the members that are restricted to their pharmacy.

PRIOR AUTHORIZATIONS

The Prior Authorization (PA) program is one of the most widely used, cost-effective methods for managing inappropriate drug use and increasing drug costs.

The PA programs are developed by the Clinical Pharmacy Service team and presented to the Pharmacy and Therapeutics (P&T) Committee for review and approval.

Drugs are selected for PA based on quality of care issues, cost and/or utilization trends. The PA program complies with Section 1927 (d) of the Social Security Act. PAs may be used under the following conditions:

- For prescribing and dispensing medically necessary non-formulary drugs
- To limit drug coverage consistent with the provisions of the Medicaid contract
- To minimize potential drug over-utilization
- To accommodate exceptions to Medicaid drug utilization review standards related to proper maintenance drug therapy
- To ensure appropriate utilization of medical injectable, specialty and oncology products that are typically administered as a component of the medical benefit

Clinical policies and procedures are developed by the Clinical Pharmacy Service team to define applicable criteria to allow coverage for drugs subject to one of the above conditions. These policies and procedures are reviewed and approved by the P&T Committee. Where states have specific requirements, their criteria and management programs are implemented.

If necessary, a 72-hour supply of medication may be dispensed by the retail pharmacy without PA through the use of an override code, while awaiting a PA decision.

The decision to approve or deny the request for PA is made within 24 hours of receipt of all necessary information. If the prescriber has not responded to the Pharmacy department's request to obtain the information needed to make the decision within 72 hours, the decision time frame will have expired, and notice will be provided to the prescriber and member.

If the request is denied, the prescriber and member are notified. In addition, a letter indicating the reason for the denial/noncertification is sent to the member and prescriber within 24 hours of rendering the decision, and the denial/noncertification letter includes the appeals procedure. A copy of the denial/noncertification letter is maintained on file in the Pharmacy department.

All PA requests are processed and recorded using a web-based application maintained by Anthem. This database is used for reporting such requests, approvals and denials/noncertifications for monthly and quarterly reports as well as state required reports.

The Anthem Blue Cross PA process continuously monitors the exception process and trends are reviewed by the P&T Committee. These reviews evaluate the consistency of management and timeliness of review and authorization.

Anthem Blue Cross contracts with the pharmacy benefit manager (PBM) for the processing of PAs using the state's required criteria as well as required turnaround times.

PEER-TO-PEER REVIEW

Providers may request a peer-to-peer conference with a Medical Director to discuss PA decisions by calling Anthem Peer-to-Peer at:

1-844-410-0746, option 3In this case, we will make a Medical Director available to discuss the case with the requesting provider. This conversation may result in the decision being upheld or changed.

PHARMACY BENEFIT MANAGER

DESCRIPTION OF PBM SERVICES

All pharmacies contracted with our pharmacy benefit manager (PBM), IngenioRx, are required to provide traditional retail pharmacy products and services following contract standards.

Network development and management is the responsibility of the PBM and includes access and availability standards, contracting, provider standards, compliance with formulary programs, pricing and general contract management. PBM responsibilities include but are not limited to:

- Claim processing accuracy
- Eligibility processing
- Network access
- Prompt payment
- State or federal provider exclusions/sanctions
- Help desk performance
- Network audits
- Fraud, waste and abuse activity
- Drug utilization review
- Delegated functions such as drug recalls and prior authorization activity

PHARMACY NETWORK AUDITS

Part of IngenioRx's responsibility is to review the performance of the pharmacy network to ensure claims processing standards are followed. They do this by conducting periodic audits of pharmacies identified as meeting certain thresholds.

The results of these audits are shared with the Pharmacy and Corporate Investigations departments. Pharmacies are required to return the overpayments and may be subject to other corrective actions by IngenioRx up to and including removal from the network.

Anthem Blue Cross is contracted with a vendor to perform Anthem Blue Cross-specific pharmacy audits and to further identify potential fraud. The results of these audits are shared with the Pharmacy and Corporate Investigations departments.

Pharmacies are required to return the overpayments, and Anthem Blue Cross may direct IngenioRx to take corrective action up to and including removal from the network.

CLAIMS PROCESSING

The PBM provides online transaction processing (OLTP) systems and online operational reporting systems. The PBM also provides the Pharmacy department with real-time access to the claim adjudication system for review of member prescription history and entering of approved prior authorizations.

Pharmacies submit claims using HIPAA-approved National Council for Prescription Drug Processing (NCPDP) standard D.0 transactions along with the prescriber.

The claims are priced according to the PBM pharmacy provider contract in place with that pharmacy and an authorization of payment message is returned to the pharmacy confirming coverage and payment. These transactions take on average less than three seconds.

CLAIMS PROCESSING EDITS

The Anthem Blue Cross Clinical Pharmacy Service team works with the delegated PBM's clinical and technical staff to build all benefit design and utilization management system edits.

Hard, soft, contingent therapy and step therapy edits are effective methods for controlling costs and providing educational messaging to pharmacies regarding the drug benefit. Edits and management practices are consistent with state and CMS regulatory requirements.

These edits all occur at the time the prescription is being filled through electronic communication with the claims system. The clinical pharmacists are responsible for developing edits related to formulary and benefit management activities.

- Hard edits: These edits stop prescriptions at the point of sale (in the pharmacy), requiring the dispensing pharmacist to take action to

ensure appropriate utilization of the medication prior to the dispensing. This action can include discussion with the prescriber, which may result in a medication, dosage or quantity change or a contact to The Anthem Blue Cross Pharmacy department for further discussion. Examples of hard edits include eligibility verification, drug coverage limits, non-formulary drugs, quantity, days' supply, PA, early refill and the highest potential risk drug-drug interaction.

- Soft edits: These edits provide educational messaging to pharmacies designed to provide the pharmacist with additional information on certain drugs. These edits do not stop the prescription from being filled. Examples of soft edits include lower potential risk drug-drug interactions or preferred formulary messaging.
- Contingent therapy edits: These edits are designed to concurrently review the electronic medication history of the member to determine if certain clinical criteria are met. If the criteria are met, the prescription can be filled without requiring PA. If the criteria are not met, the system provides messaging regarding the preferred first-line agent or refers the pharmacy to contact The Anthem Blue Cross Pharmacy department. An example of a contingent therapy edit is the requirement that a member has previously tried other non-steroidal anti-inflammatory medication prior to receiving a COX-II inhibitor.

SPECIAL DRUG PROCEDURES

SPECIALTY MEDICATIONS

Specialty medications such as Synagis, Makena, and Botox will require PA through Anthem Blue Cross.

SELF-INJECTABLE MEDICATIONS

Anthem Blue Cross has delegation arrangements with certain participating medical groups (PMGs) who agree to provide their assigned members' self-injectable medications including but not limited to Humira, Enbrel, Copaxone, Stelara, Kineret, and Avonex.

Members belonging to PMGs with this arrangement will receive a hard edit claim reject at the pharmacy. The pharmacy should instruct the member to obtain the self-injectable medication through their medical provider. Typically, the medical provider's group has an arrangement with a specialty pharmacy which can supply the patient's medication.

Members belonging to PMGs without the self-injectable arrangement will be able to receive their self-injectable medications from The Anthem Blue Cross pharmacy network (see Pharmacy Network).

PHYSICIAN-ADMINISTERED DRUGS

Physician-administered drugs are typically billed using HCPCS codes. Coverage policies must be obtained by contacting Anthem Blue Cross Utilization Management.

COMPOUND DRUGS

Compound drugs are prescriptions that are mixed, combined or altered to create medication tailored to the needs of an individual patient. Compounds can be covered when all of the following conditions are met:

- A commercial formulation of medication is not available
- All active ingredients are FDA-approved
- All active ingredients require a prescription to dispense
- The compound drug is not essentially the same as an FDA-approved product marketed by a drug manufacturer

Compound drugs are not covered when:

- A commercial formulation is available
- Active ingredients are not FDA-approved
- Active ingredients are not CMS-rebateable (the manufacturer has not signed rebate agreements with CMS)

- The compound includes proprietary vehicles, bases and/or other pharmaceutical adjuvants

OPIATE PRESCRIBING

To address the risk of opioid dependence, overdose and death, Anthem Blue Cross has instituted special limits on opioid prescriptions:

- Short-acting opiates are limited to two 7-day prescriptions per 30 days. Exceeding this duration will require prescribers to submit a PA request detailing clinical rationale.
- Long-acting opiates including formulary agents now require PA for all new patient starts.

SPECIAL FILL PROCEDURES

PHARMACY EMERGENCY SUPPLIES

A pharmacist or hospital emergency room may dispense a 72-hour emergency supply to a member awaiting a PA decision as warranted. An emergency is when lack of medical help could result in danger to a member's health or, in the case of a pregnant member, the health of her unborn child.

All participating pharmacies will be reimbursed for the ingredient cost and dispensing fee of the 72-hour emergency supply of medication, whether or not the PA request is ultimately approved or denied.

☎ The pharmacy must call IngenioRx Pharmacy Help Desk at IngenioRx Pharmacy Help Desk

☎ **1-833-253-4454** for a prescription override to submit the 72-hour medication emergency supply for payment.

Excluded and carved-out medications/products are not eligible for a 72-hour emergency supply.

LOST OR STOLEN MEDICATIONS

Anthem Blue Cross does not routinely provide payment for replacement of lost, stolen or otherwise destroyed medications, even if a physician writes a new prescription for the medication. It is the responsibility of the member to replace these medications.

PA may be considered in life-threatening situations and for maintenance medications only when the following conditions are met:

- The member must provide detailed information regarding how the medication was lost or stolen.
- If the medication was stolen, a copy of the official police report will be required.
- Based on clinical judgment of the reviewing clinical pharmacist, contact may be made with the prescriber to confirm his/her knowledge of the situation and the approval for replacement medication.
- Habitual requests for replacement medications will be referred to the health plan Medical Director and/or Medicaid Special Investigations Unit.
- Replacement of narcotics or controlled substances is prohibited.

PHARMACY PROGRAMS

PRESCRIPTION DRUG MONITORING PROGRAM

Prescribers and dispensers are encouraged to register for CURES access as soon as possible in observance of mandates established by CA SB809 and SB482.

California Health & Safety Code section 11165.1 (a)(1)(A) states that health care practitioners authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III or Schedule IV controlled substances and pharmacists must submit an application for approval to access information online regarding the controlled substance history of a patient.

Providers should review six-month prescription profiles and/or California prescription drug monitoring program (CURES) report with the member, pointing out the importance of appropriate drug use and avoidance of drug interactions. SB482 requires providers to consult CURES in

advance of prescribing certain controlled substances.

More information about CURES, including registration information, may be found at:

http://oag.ca.gov/cures-pdmp

COORDINATION OF BENEFITS

Medicaid is the payer of last resort. In order to properly adjudicate pharmacy claims, the pharmacy claims system also edits for coordination of benefits (COB) using a COB flag that is sent on the member eligibility record. Following NCPDP standards, the pharmacy enters certain codes indicating payment made by the primary insurer, and Anthem Blue Cross covers the member's remaining out-of-pocket expense. For members with commercial primary coverage, Anthem Blue Cross can cover member prescription deductibles and copays.

- For members with Medicare Part B, Anthem Blue Cross can cover the member's 20% cost share.
- For members with Medicare Part D, Anthem Blue Cross covers select drugs which are covered by Medicaid but not Medicare Part D.
- Anthem Blue Cross does not cover Part D deductibles, copays or catastrophic member cost share payments.

ADMINISTRATIVE

PHARMACY AND THERAPEUTICS PROCESS

The Pharmacy and Therapeutics (P&T) process consists of two interdependent subcommittees: the Clinical Review Committee (CRC) and the Value Assessment Committee (VAC).

Clinical Review Committee (CRC): The purpose of the CRC is to clinically review drugs for safety, efficacy and clinical aspects in comparison to similar drugs within a therapeutic class or used to treat a particular condition. The committee's main goal is assignment of clinical designations to each single-source brand product under review.

Value Assessment Committee (VAC): The role of the VAC is to determine tier assignments, or coverage levels. In addition to the designations assigned by the CRC, the VAC may also look at financial information (i.e., average wholesale price, rebates, ingredient cost, cost of care, copayments, coinsurance), market factors and customer impact to determine tiers/levels. The VAC is responsible for creating tier assignments that appropriately balance clinical, financial and customer impact.

These designations are determined through a rigorous review of clinical evidence, the product's clinical attributes and clinical judgment.

The CRC may assign one of four clinical designations:

1. Favorable
2. Comparable
3. Insufficient evidence
4. Unfavorable

These designations are passed to a second committee known as the Value Assessment Committee (VAC). The CRC may also choose to provide the VAC with clinical comments about the products to assist in further defining their clinical rationale.

The CRC may also provide clinical comments about any generics in that particular drug class as well. To ensure that the clinical rationale is properly balanced with financial considerations, the VAC must take into account the CRC's clinical designations and review the clinical comments when making decisions. The CRC always meets before the VAC.

CLINICAL POLICY DEVELOPMENT

The development of clinical drug policies is critical to the success of the PA program and to ensure appropriateness and quality of care. The pharmacists and Medical Directors use the policies as a guideline in determining medical necessity of those drugs requiring PA.

The clinical pharmacists use several clinical resources to gather the most current information regarding FDA approved indications, dosing,

contraindications and other relevant information that would be required to determine medical necessity.

These resources include but are not limited to: FDA-approved product labeling, peer-reviewed literature, American Hospital Formulary Service Drug (AHDS) Information®, Truven Health Analytics Inc. DrugPoints® or DrugDex®, National Comprehensive Cancer Network (NCCN) ® Drug & Biologicals Compendium®.

The policies are presented to the P&T Committee for review and approval. Clinical drug policies are updated at least annually so that the most current clinical information is being utilized in medical necessity determinations.

FDA DRUG RECALLS AND PATIENT SAFETY

Drug recalls are defined by the FDA and recognized by NCQA as follows:

- Class I recall: a situation in which there is a reasonable probability that the use of or exposure to a volatile product will cause serious adverse health consequences or death.
- Class II recall: a situation in which use of or exposure to a volatile product may cause temporary or medically reversible adverse health consequences or where the probability of serious adverse health consequences is remote.
- Class III recall: a situation in which use of or exposure to a volatile product is not likely to cause adverse health consequences.
- Market withdrawal: occurs when a product has a minor violation that would not be subject to FDA legal action. The firm removes the product from the market or corrects the violation. For example, a product removed from the market due to tampering without evidence of manufacturing or distribution problems would be a market withdrawal.
- Medical device safety alert: issued in situations where a medical device may present an unreasonable risk of substantial harm. In some cases, these situations are also considered recalls.

In the event of a drug recall either voluntarily by the manufacturer or as a result of an FDA requirement, Anthem Blue Cross ensures appropriate notification is provided to members and providers in compliance with NCQA guidelines.

MANAGED LONG-TERM SERVICES AND SUPPORTS

Managed Long-Term Services and Supports (MLTSS) consists of a variety of state of California programs that provide services to help individuals remain living independently in the community or the most appropriate setting of their choice. MLTSS are provided over an extended period, predominantly in the member's home or community, but also in facility-based settings such as nursing facilities.

MLTSS consist of four distinct benefits:

- Coordination of In-Home Support Services (IHSS)
- Community-Based Adult Services (CBAS)
- Multipurpose Senior Services Program (MSSP)
- Long-Term Care (LTC)

Since the 2014 implementation of California's Coordinated Care Initiative (CCI), Anthem Blue Cross has taken responsibility for these programs in Santa Clara and Los Angeles Counties. In these two counties, most Medi-Cal beneficiaries, including dual eligibles, must join a Medi-Cal managed care health plan like Anthem Blue Cross to receive MLTSS and other Medi-Cal benefits.

By providing MLTSS and connecting members to other home- and community-based services (HCBS), Anthem Blue Cross works to ensure that members are getting the right care, in the right place, and at the right time.

With the exception of CBAS, MLTSS is not a part of the Anthem Blue Cross benefit package outside of Los Angeles and Santa Clara counties. However, IHSS and MSSP are still available to members as carved-out benefits. Members requiring LTC are disenrolled from managed care so they may receive LTC services through FFS Medi-Cal. Anthem Blue Cross will refer to those programs for members enrolled outside of Santa Clara and Los Angeles counties when applicable.

Anthem Blue Cross maintains responsibility for CBAS services in all of our California Medicaid counties through a separate program implementation rolled out by the state in 2012.

CONSUMER DIRECTION

MLTSS are provided under models that promote consumer direction. Members have a voice in how eligible MLTSS services are provided, who provides the services, and what goals they want prioritized within their MLTSS plans of care.

MLTSS SERVICE COORDINATION

The Anthem Blue Cross MLTSS team works to support member choice and independence by providing access to and coordination of services and supports. This allows members to live with dignity in their community or LTC facility, improving their quality of life.

To ensure members' needs are being met, MLTSS staff work closely with our Case Management and Behavioral Health teams, PCPs, and MLTSS providers to identify and connect with members who could benefit from MLTSS services. This includes:

- Identification of needs through the review of Health Risk Assessments and other member assessments
- Review and processing of referrals from PCP, specialists and MLTSS providers
- Coordination with members, family, providers and case managers as needed to implement a plan of care
- Review of MLTSS provider care plans and coordination with providers on additional support
- Assistance in determining the right combination of MLTSS supports
- Assistance in accessing MLTSS and other home- and community-based services

- Assistance with caregiver issues, community resource referrals, emergency needs, financial assistance, housing arrangements, long-term care planning and nursing home placement discussions
- Assistance with transitions from skilled nursing facilities back to the community

IN-HOME SUPPORT SERVICES

IHSS allows eligible seniors and persons with disabilities to hire a homecare worker to assist them with their activities of daily living, instrumental activities of daily living and other personal needs so they can remain safely in their homes. Members receiving IHSS self-direct their own care by hiring, managing and, if necessary, firing their homecare workers. Members can also elect to involve their IHSS homecare workers as members of their care teams.

Types of Services Provided by IHSS Homecare Workers

Examples of services that can be provided by IHSS homecare workers include:

- Domestic and related services (i.e., house cleaning/chores, meal preparation and clean-up, laundry, grocery shopping, heavy cleaning)
- Personal care services (i.e., bathing and grooming, dressing, feeding)
- Paramedical services (i.e., administration of medication, puncturing skin, range of motion exercises)
- Other services (i.e., accompaniment to medical appointments, yard hazard abatement, protective supervision)

IHSS Eligibility and Referral Process

To be eligible for IHSS, a member must:

- Reside in California, be a U.S. citizen/legal resident and be living in his or her own home
- Be eligible to receive Medi-Cal benefits
- Be 65 years of age or older, legally blind or disabled by Social Security standards
- Submit a health care certification form (SOC 873) signed by a licensed health care professional indicating that they need assistance to stay living at home

The IHSS program is administered by the county, and county social workers are responsible for assessing, approving and authorizing service hours based on the needs of the member.

The county (or delegated IHSS Public Authority) is also responsible for screening and enrolling IHSS homecare workers, conducting criminal background checks, conducting homecare worker orientations, operating homecare worker registries and retaining enrollment documentation.

Members who may benefit from IHSS or who need assistance navigating the program can contact an Anthem Blue Cross MLTSS Service Coordinator at:

☎ **1-855-871-4899**

Members may also self-refer and apply directly with the county by calling the IHSS Application Hotline at:

☎ **1-888-944-IHSS** (Los Angeles County)

☎ **1-408-792-1600** (Santa Clara County)

COMMUNITY BASED ADULT SERVICES

CBAS is a facility-based outpatient program serving individuals 18 years of age or older who have functional impairment that puts them at risk for institutional care. For additional information on CBAS, see **Chapter 4: General Benefits**.

MULTIPURPOSE SENIOR SERVICES PROGRAM

MSSP is an intensive case management program that coordinates social and health care services for members who are eligible for nursing facility placement, but who wish to remain in the community.

Contracted MSSP providers work with members to develop a care plan, assist the member in accessing services available in the community (i.e., MLTSS or HCBS), and pay for additional services to assist the member with other unmet needs.

Types of services provided by MSSP include:

- Care management (i.e., needs assessments, care plan development, monitoring of care)
- Care management assistance (i.e., assistance accessing services, personal advocacy)
- MSSP purchased services* (i.e., supplemental chore and personal care services, diet and nutrition, handyman services, respite care, transportation, appliance assistance, housing assistance/repair, personal emergency response systems)

* Approved purchased services are listed and defined in the MSSP Provider Site Manual located on the California Department of Aging website at:

https://www.aging.ca.gov/ProgramsProviders/MSSP

MSSP Eligibility and Referral Process

The MSSP program currently operates under a California 1915c HCBS Waiver and there are a limited number of slots available for members. Eligibility and authorization of services is determined by The Anthem Blue Cross contracted MSSP providers based on criteria set by the state.

In general, to be eligible for MSSP services a member must:

- Be 65 years of age or older
- Live within an MSSP service area
- Be eligible for Medi-Cal
- Be certified for nursing home placement

To begin the referral process for a member, please contact Anthem Blue Cross at:

☎ **1-855-871-4899**

An MLTSS care coordinator will assist the member with locating an MSSP provider and navigating the application process. For members who are placed on an MSSP's waiting list, the coordinator will work with the MSSP provider and other HCBS providers to address the member's needs until he or she can be enrolled in the program.

MSSP Payment Procedures

MSSP providers are paid a flat per member per month (PMPM) rate that has been established by DHCS and must submit a monthly invoice to Anthem Blue Cross no later than the tenth day of each month. The invoice shall include information on each Anthem Blue Cross member enrolled in the program as of the first day of the month for which the report is submitted. The invoice must include the following information:

- The name of the Anthem Blue Cross member receiving the MSSP services
- The member's Client Index Number (CIN)
- The MSSP provider's ID number
- Other relevant information as identified by both Anthem Blue Cross and the MSSP

MSSP providers may not submit separate claims to different plans for the same MSSP recipient within the same invoice period. MSSP providers must also submit zero-cost encounter data to Anthem Blue Cross within 60 days from the date of services for reporting purposes. Any questions related to MSSP billing and payments should be directed to the MLTSS Provider Relations Representative or to LTSSProviders@anthem.com.

LONG-TERM CARE AND SKILLED NURSING FACILITIES

Long-Term Care (LTC) is the provision of care in a facility, such as a skilled nursing facility or sub-acute facility for an extended period (i.e., longer than the month of admission plus one month).

LTC services are primarily for the purpose of assisting the member with their activities of daily living or in meeting personal rather than medical needs. LTC does not include specific therapy for an illness or injury, is not skilled care, and does not require the continuing attention or supervision of trained, medical or paramedical personnel.

LTC Eligibility And Referral Process

LTC services are available to Medi-Cal recipients who require 24-hour long or short-term care and have a written order from their PCP requesting the services.

Requests for LTC authorizations should be submitted prior to the first day of service and no later than 30 days past the first day of service. General guidelines for obtaining a prior (PA) authorization for LTC services are as follows:

- Requests for authorizations must include a completed LTC authorization request form, a Medication Administration Record (MAR) and the most recent Minimum Data Set (MDS) for the member.
- Facilities who have multiple members needing authorization for LTC services should submit each request separately via fax.

PA requests should be faxed to:

☎ **1-877-279-2482** (Los Angeles County)

☎ **1-844-285-1167** (Santa Clara County)

An LTSS service coordinator will review the request and determine if the member qualifies for LTC placement following clinical guidelines established by DHCS.

LTC Claims and Reimbursement

PAs are required for all LTC services. Providers rendering LTC services should submit claims to Anthem Blue Cross using the appropriate CPT and accommodation codes.

There are several nuances specific to LTC that should be taken into consideration when navigating the LTC billing and payment process. This includes retroactive eligibility, authorizations for LTC absences, member share of cost, and the relationship between LTC and hospice.

Retroactive Eligibility

Anthem Blue Cross understands the unique requirements of LTC facilities to accept residents as Medi-Cal pending. As soon as the facility receives notice from the state of the Medi-Cal approval, the facility should verify eligibility on the Anthem Blue Cross website and then request an authorization back to the date of eligibility as established by the state.

Note: It may take the state 24 to 48 hours to transmit an updated eligibility file to Anthem Blue Cross.

Authorized LTC Absences

LTC facilities are allowed to request a bed hold for up to seven days when an LTC member leaves a facility and is admitted to an acute care facility or hospital. To ensure accurate payment, the facility must bill hospital leave days consecutively beginning with the date of admission. If a beneficiary goes to a hospital for observation purposes and is not admitted, the LTC facility should bill for this as a normal day of service.

In the event of a nonmedical absence from an LTC facility, providers must obtain an authorization and bill utilizing the appropriate end hold/leave of absence revenue code and accommodation code. A maximum of 18 home-leave days for LTC are allowed per calendar year (certain exceptions may apply).

Providers will not be reimbursed for days a bed is held for a resident beyond the limits set forth above and will not be reimbursed for any absences without preauthorization.

Member Financial Liability/Share of Cost

For members who have a Medi-Cal share of cost (SOC), the LTC facility is responsible for collecting the SOC amount each month and must represent the liability in **box 39** on each claim submitted. The SOC should be indicated by billing value code 23 with amount collected on the claim. The payment remitted by Anthem Blue Cross will be reduced by the member liability amount.

The following examples are provided to assist LTC facilities with addressing member SOC.

Example 1: The member is approved for LTC as of the 1st of the month, remains in the facility for the entire month, and has a $1,000 Medi-Cal SOC.

- The state issues a notice of action for the month for the amount of $1,000
- The facility per diem is $150: 150 x 30 = $4,500
- The facility collects the $1,000 patient liability and submits a claim to Anthem Blue Cross representing the collected amount in box 39
- Anthem Blue Cross will make a payment to the facility in the amount of $3,500

Example 2: The member is approved for LTC as of the 15th of the month, remains in the facility through the end of the month, and has a $1,000 Medi-Cal SOC (of which, $400 has been met).

- The state issues a notice of action for the month for the amount of $600 and for the following month forward of $1,000 per month
- The facility per diem is $150: 150 x 15 = $2,250
- The facility collects the $600 patient liability and submits a claim to Anthem Blue Cross representing the collected amount in box 39
- Anthem Blue Cross will make a payment to the facility in the amount of $1,650
- The facility will collect $1,000 from the patient in the following month

Example 3: The member is approved for LTC as of the 1st of the month and has a $1,000 Medi-Cal SOC. However, the member is discharged on the 6th day of the month.

- The state issues notice of action for the month for the amount of $1000
- The facility per diem is $150 and the facility collects the $1000 patient liability on the first of the month
- The member is discharged on day 6: 6 x $150 = $900
- The facility refunds $100 to the member/family or estate and submits a claim to Anthem Blue Cross representing the $900 collected in box 39
- Anthem Blue Cross will make a payment to the facility in the amount of $0

LTC and Hospice

When a member is admitted into an LTC facility and is receiving hospice, the hospice provider is responsible for obtaining an authorization for LTC services and is required to pay the facility for room and board charges in accordance with CMS methodology and at the current applicable Medi-Cal rate. Anthem Blue Cross is responsible for paying the hospice provider for all services rendered but is not responsible for paying the LTC facility directly for these services.

HEALTH HOMES

Health Homes is a new program being designed under ACA Section 2703 and California Assembly Bill 361 to provide an integrated (physical and behavioral), person-centered service delivery system for populations with complex/chronic conditions or serious mental illness.

Health Homes is intended to be an intensive set of services for a small subset of members who could benefit from high-touch care coordination services. Anthem Blue Cross has committed to implementing Health Home pilots in seven counties, beginning in July 2018 in San Francisco and Alameda. In July 2019, the program will launch in Santa Clara, Los Angeles, Tulare, and Sacramento.

7 | SPECIAL PROGRAMS AND PILOTS

The Health Homes program provides a unique group of services compared to other care coordination programs provided by Anthem Blue Cross and our partners. In its current design, the program will place a stronger emphasis on:

- Addressing homelessness/unstable housing for members
- Improving HIT/HIE and other data-sharing capabilities
- Pushing care management/care coordination to community-level providers
- Additional care management and care coordination services above currently contracted services
- More intense levels of outreach and engagement
- Development and sharing of a health action plan
- Medication reconciliation services
- Enhanced transitional care services

In order to achieve the goals set forth under the Health Homes Program, Anthem Blue Cross will be contracting with Community Based Care Management Entities (CB-CMEs) who will be responsible for

- Comprehensive care management
- Care coordination (physical health, behavioral health, community-based LTSS)
- Health promotion
- Comprehensive transitional care services
- Individual and family support
- Referral to community and social support services

Organizations who may act as CB-CMEs include FQHCs, community health centers, community mental health centers, local health departments, primary care or specialist physician groups, SUD treatment providers, providers serving individuals experiencing homelessness, CBAS providers or other community-based organizations.

ELIGIBILITY

Eligible members for the Health Homes program must meet the following criteria:

Chronic Condition Criteria

Has a chronic condition in at least **one** of the following categories:

- At least two of the following: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, dementia, substance use disorders
- Hypertension and one of the following: chronic obstructive pulmonary disease, diabetes, coronary artery disease, chronic or congestive heart failure
- One of the following: major depressive disorders, bipolar disorder, psychotic disorders (including schizophrenia)
- Asthma

Medical Acuity/Complexity Criteria

Meets at least **one** of the following criteria:

- Has at least three of the eligible chronic conditions
- At least one inpatient stay in the last year
- Three or more emergency department visits in the last year
- Chronic homelessness

REFERRAL PROCESS

Providers can refer members they determine would benefit from Health Homes program services and must attest the member meets the eligibility criteria. Referrals must be submitted to our Special Programs department for review at CAHealthHomes@anthem.com.

We'll review all referrals to confirm members meet the eligibility criteria. Members determined eligible will be assigned a CB-CME for outreach and engagement.

Additional information can also be found on the Anthem Blue Cross provider website at:

https://mediproviders.anthem.com/ca

WHOLE PERSON CARE

Whole Person Care (WPC) pilots are five-year demonstration programs authorized under the state of California's Medi-Cal 2020 waiver to test locally based initiatives that will coordinate physical health, behavioral health and social services for beneficiaries who are high users of multiple health care systems.

WPC pilots are designed to address the needs of high utilizing Medi-Cal members who are not currently receiving similar services through other programs such as Health Homes or Cal MediConnect.

WPC places a strong emphasis on identifying target populations, establishing strong infrastructures for data sharing and care coordination, and on evaluating individual and population health progress.

WPC pilots are led by county agencies, which fund 50% of the proposed WPC activities in order to draw down a 50% federal match. Each participating county has the flexibility to design their own WPC pilot following certain guidelines and must partner with at least one local health plan. General categories of service include establishing:

- Care coordination/management programs (may utilize filed-based care, such as case managers, therapists or nurses delivering service on the street or in the home)
- Recuperative care/medical respite programs
- Sobering centers
- Transportation services
- New IT and data sharing infrastructures
- Individual housing transition services
- Individual housing and tenancy sustaining services
- Transition services
- Flexible housing pools

Anthem Blue Cross has committed to partnering with nine counties who have received CMS and DHCS approval to implement WPC pilots. This includes Los Angeles, Santa Clara, Alameda, San Francisco, Sacramento (City), San Benito, Mariposa, Kings and Placer counties.

Additional information on WPC can be found on the DHCS website at:

www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx

PALLIATIVE CARE PROGRAM

Anthem Palliative Care Program is a patient and family-centered care program that optimizes quality of life for adult members with a terminal illness. Palliative Care includes coordination of services throughout the continuum of illness to address physical, intellectual, emotional, social, and spiritual needs, and to facilitate member autonomy, access to information, and choice. Unlike the hospice benefit, members can receive palliative care services concurrently with curative care.

TYPES OF SERVICES:

Anthem contracts with Palliative Care providers in the community to deliver services, such as:

- Advanced Care Planning
- Care Coordination
- Mental Health and Medical Social Services
- Pain and Symptom Management
- Care Plan Development
- Palliative Care Assessment and Consultation

PALLIATIVE CARE ELIGIBILITY AND REFERRAL PROCESS:

In order to qualify for Anthem adult Palliative Care, members must meet all general eligibility criteria

and at least one of the disease-specific criteria listed below.

General eligibility criteria:

- Patient is likely or has started to use the hospital or emergency department to manage their late-stage disease ("unanticipated decompensation").
- Patient is in the late stage of illness.
- Patient's death within a year would not be unexpected.
- Patient has received appropriate medical therapy.
- Patient and designated support person agree to attempt in-home, residential-based or outpatient disease management and are willing to participate in advanced care planning.

Disease-specific criteria:

- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- Advanced cancer
- Liver disease

Referral Process:

To initiate a referral for Palliative Care, please contact the Palliative Care at anthempalliativecareprogram@anthem.com**.**

Additional information on Palliative Care Services can also be found on the DHCS website at:

https://www.dhcs.ca.gov/provgovpart/Page/Palliative-Care-and-SB-1004.aspx

PEDIATRIC PALLIATIVE CARE

Pediatric Palliative Care is a new benefit available to Anthem members as a part of DHCS's Palliative Care Waiver transition, and is specialized care for children with serious, long-term health conditions.

Anthem Blue Cross contracted with providers in Alameda, San Francisco, Santa Clara, San Benito and Los Angeles counties to provide Home-based services that align with the previous waiver including:

- All adult services (please see listed in Palliative Care Program)
- Specialized services:
  - Expressive therapy (creative art, music, massage, and child life)
  - Family Bereavement counseling for family and other primary caregivers as applicable
  - Respite care
  - 24/7 nursing hotline

Children residing outside of the counties listed above are able to access our standard palliative care network and services.

In order to qualify for Palliative Care, members must have one of the eligible conditions:

- Conditions for which curative treatment is possible, but may fail (e.g. advanced cancer)
- Conditions requiring intensive long-term treatment aimed at maintaining quality of life (e.g. HIV, cystic fibrosis)
- Progressive conditions for which treatment is exclusively palliative after diagnosis (e.g. progressive metabolic disorders)
- Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications (e.g. extreme prematurity)

For more information on Pediatric Palliative Care Program, including eligibility criteria, referral processes, and coordinating with providers, please contact Pediatric Palliative Care Program team at: anthempalliativecareprogram@anthem.com.

Additional information can also be found on the DHCS website at:

https://www.dhcs.ca.gov/services/ppc/Pages/default.aspx

LIVEHEALTH ONLINE (LHO)

LiveHealth Online (LHO) is a website and mobile application that gives patients 24/7 access to on-demand video visits (medical). It has an urgent care focus and provides convenient access anytime, anywhere in California (even at home!) via smartphone, tablet or computer.

LHO connects patients with board-certified physicians supporting physical and behavioral health. Physicians can electronically prescribe to the member's pharmacy. Note: Only noncontrolled substances can be prescribed. It is available at no cost for Anthem Blue Cross (Anthem) members enrolled in Medi-Cal Managed Care (Medi-Cal) beginning September 1, 2018.

LHO does **not** provide:

- Preventive or ongoing medical care.*
- Lab orders.
- Access to specialist care at this time.

Access to translation services other than Spanish (doctor profiles indicate spoken languages).

Members can get 24/7 help by calling: **1-888-548-3432 | 1-888-LiveHealth**

For urgent prescription assistance after an online visit, members can call: **1-888-982-7956**.

RESPONSIBILITIES APPLICABLE TO ALL PROVIDERS

Our providers must fulfill their roles and responsibilities with the highest integrity. We lean on their extensive health care education, experience and dedication to our members.

There are a number of responsibilities applicable to all Anthem Blue Cross providers. Responsibilities include the following:

- After-hours services
- Eligibility verification
- Collaboration
- Confidentiality
- Continuity of care
- Licenses and certifications
- Mandatory reporting of abuse
- Medical records standards and documentation
- Office hours
- Open clinical dialog/affirmative statement
- Oversight of non-physician practitioners
- Prohibited activities
- Provider contract terminations
- Termination of ancillary provider/patient relationship
- Updating provider information
- Fully complying with all terms and conditions of the DHCS contract including ownership and control disclosures, audits and inspections of subcontractors, and monitoring activities related to care coordination, data reporting and other functions

PROHIBITED ACTIVITIES

- Billing eligible members for covered services
- Segregating members in any way from other persons receiving similar services, supplies or equipment
- Discriminating against Anthem Blue Cross members or Medicaid participants

Note: Services should always be provided without regard to race, religion, sex, color, national origin, age or physical/behavioral health status.

EMERGENCIES

The answering service or after-hours personnel must ask the member if the call is an **emergency**. In the event of an emergency, the member must be immediately directed to **dial 911** or to proceed directly to the nearest hospital emergency room.

If the PCP's staff or answering service is not immediately available, an answering machine may be used. The answering machine message must instruct members with emergency health care needs to dial 911 or go directly to the nearest hospital emergency room. The message must also give members an alternative contact number so they can reach the PCP or on-call provider with medical concerns or questions.

NETWORK ON-CALL PROVIDERS

Anthem Blue Cross prefers that our PCPs use network providers for on-call services. When that is not possible, the PCP must help ensure that the covering on-call physician or other professional provider abides by the terms of our provider contract.

COLLABORATION

Providers share the responsibility of giving respectful care and working collaboratively with Anthem Blue Cross specialists, hospitals, ancillary providers, and members and their families. Providers must permit members to participate actively in decisions regarding medical care including, except as limited by law, their decision to refuse treatment.

MANDATORY REPORTING OF CHILD ABUSE, ELDER ABUSE OR DOMESTIC VIOLENCE

Providers must ensure that office personnel have specific knowledge of local reporting requirements and procedures to make telephone and written reports of known or suspected cases of abuse.

All health care professionals must immediately report actual or suspected child abuse, elder abuse or domestic violence to the local law enforcement agency by telephone. In addition, providers must submit a follow-up written report to the local law enforcement agency within the time frames as required by law.

OPEN CLINICAL DIALOGUE/AFFIRMATIVE STATEMENT

Nothing within the provider's *Provider Agreement* or this *Provider Manual* should be construed as encouraging providers to restrict medically necessary covered services or limit clinical dialogue between providers and their patients. Providers can communicate freely with members regarding the treatment options available to them including medication treatment options regardless of benefit coverage limitations.

OVERSIGHT OF NONPHYSICIAN PRACTITIONERS

All providers using nonphysician practitioners must provide supervision and oversight of such nonphysician practitioners consistent with state and federal laws. The supervising physician and the nonphysician practitioner must have written guidelines for adequate supervision, and all supervising providers must follow state licensing and certification requirements.

Nonphysician practitioners include the following categories:

- Advanced registered nurse practitioners
- Certified nurse midwives
- Physician assistants

These nonphysician practitioners are licensed by the state and working under the supervision of a licensed physician as mandated by state and federal regulations.

PROVIDER RIGHTS

Anthem Blue Cross providers acting within the lawful scope of practice shall not be prohibited from advising a member or advocating on behalf of a member for any of the following:

- The member's health status, medical care or treatment options including any alternative treatment that may be self-administered
- Any information the member needs in order to decide among all relevant treatment options
- The risks, benefits and consequences of treatment or nontreatment
- The member's right to participate in decisions regarding his or her health care including the right to refuse treatment and to express preferences about future treatment decisions
- To receive information on the grievances and appeals and state fair hearing procedures
- To have access to policies and procedures covering authorization of services
- To be notified of any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested
- To challenge, on behalf of our members, the denial of coverage or payment for medical assistance
- To be free from discrimination for the participation, reimbursement or indemnification of any provider who is acting within the scope of his/her license or certification under applicable law solely based on that license or certification

Anthem Blue Cross provider selection policies and procedures do not discriminate against particular providers who serve high-risk populations or specialize in conditions that require costly treatment.

Note: Anthem Blue Cross members may select any contracted PCP as their primary physician as long as that PCP is taking new patients. We furnish each PCP with a current list of assigned members and from time to time provide medical information about our members' potential health care needs. In this way, providers can more effectively provide care and coordinate services.

HOSPITAL SCOPE OF RESPONSIBILITIES

PCPs refer members to contracted hospitals for conditions beyond the PCP's scope of practice that are medically necessary.

Hospital care is limited to Anthem Blue Cross benefits. Hospital professionals diagnose and treat conditions specific to their area of expertise. Hospital responsibilities include the following.

SUPPLY MEDICATIONS

Hospital providers must provide members with an adequate supply of medications upon discharge from the emergency room or an inpatient setting to allow reasonable time for the member to access a pharmacy to have prescriptions filled.

NOTIFICATION OF ADMISSION AND SERVICES

The hospital must notify Anthem Blue Cross or the review organization of an admission or service at the time the member is admitted or service is rendered.

In the event that the emergency room visit results in the member's admission to the hospital, providers must contact Anthem Blue Cross within 24 hours or one business day if the member was admitted on a weekend or holiday.

NOTIFICATION OF PRIOR AUTHORIZATION DECISIONS

If the hospital has not received notice of prior authorization at the time of a scheduled admission or service as required by the Utilization Management guidelines and the Hospital Agreement, the hospital should contact Anthem Blue Cross and request the status of the decision.

Any admission or service that requires prior authorization and has not received the appropriate review may be subject to post-service review denial. Generally, the provider is required to perform all prior authorization functions with Anthem Blue Cross; however, the hospital may also ensure that prior authorization has been granted before services are rendered or risk post-service denial.

ANCILLARY SCOPE OF RESPONSIBILITIES

PCPs and specialists refer members to contracted network ancillary providers for conditions beyond the PCP's or specialist's scope of practice that are medically necessary.

Ancillary professionals diagnose and treat conditions specific to their area of expertise. Ancillary care is limited to Anthem Blue Cross benefits.

We have a wide network of participating health care professionals and facilities. All services provided by the health care professional and for which the health care professional is responsible are listed in the *Ancillary Agreement*.

ACCESS TO CARE, APPOINTMENT STANDARDS AND AFTER-HOURS SERVICES

Anthem Blue Cross adheres to standards set by the following organizations:

- National Committee for Quality Assurance (NCQA)
- American College of Obstetricians and Gynecologists (ACOG)
- Department of Health Care Services (DHCS)
- California Department of Managed Health Care (DMHC)

These guidelines help ensure that medical appointments, emergency services and continuity of care for new members are provided fairly, reasonably and within specific time frames.

Anthem Blue Cross monitors provider compliance with access to care standards on a regular basis.

Failure to comply with proper instructions, standards or survey requests may result in corrective action.

AMERICANS WITH DISABILITIES ACT REQUIREMENTS

Our policies and procedures are designed to promote compliance with the Americans with Disabilities Act (ADA) of 1990. Providers are required to take reasonable actions to remove an existing barrier and/or to accommodate the needs of members who are qualified individuals with a disability. This action plan includes:

- Street-level access
- An elevator or accessible ramp into facilities
- Access to a lavatory that accommodates a wheelchair
- Access to an examination room that accommodates a wheelchair
- Hanicap parking clearly marked, unless there is street side parking

APPOINTMENT STANDARDS

Health care providers must make appointments for members from the time of request as follows:

Emergency examination	Immediate access, 24 hours/7 days a week
Urgent (sick) examination	Within 48 hours of request if authorization is not required or within 96 hours of request if authorization is required, or as clinically indicated
Routine primary care examination (nonurgent)	Within 10 business days of request
Nonurgent consults/specialty referrals	Within 15 business days of request
Nonurgent care with nonphysician mental health providers (where applicable)	Within 10 business days of request
Nonurgent ancillary	Within 15 business days of request
Initial health assessments	Within 120 days of enrollment
Preventive care visits	Within 14 days of request
Routine physicals	Within 30 days of request
Behavioral health	
Standards for timely and appropriate access to quality behavioral health care	Emergent: immediately Emergent, nonlife-threatening/crisis stabilization: within 24 hours of request Urgent: within 48 hours of referral/request Initial visit for routine care within 10 business days
Outpatient treatment by a behavioral health provider post-inpatient discharge	7 calendar days Routine outpatient: within 10 days of request Outpatient following discharge from an inpatient hospital: within 7 days of discharge
Initial health assessments	
Children under the age of 18 months	Within 120 days of enrollment or within American Academy of Pediatrics (AAP) guidelines, whichever is less
Children aged 19 months and over	Within 120 days of enrollment
Prenatal and post-partum visits	
First prenatal visit	Within 10 days of request
First and second trimester	Within 7 days of request
Third trimester	Within 3 days of request
High-risk pregnancy	Within 3 days of identification
Postpartum	Between 21 and 56 days after delivery

MISSED APPOINTMENT TRACKING

When members miss appointments, providers must do the following:

- Document the missed appointment in the member's medical record.
- Make at least three attempts to contact the member to determine the reason for the missed appointment.
- Provide a reason in the member's medical record for any delays in performing an examination including any refusals by the member.
- Documentation of the attempts to schedule an **initial health assessment** must be available to Anthem Blue Cross or state reviewers upon request.

SPECIALISTS

The following guidelines are in place for our specialists:

- For urgent care, the specialist should see the member within 24 hours of receiving the request.
- For routine care, the specialist should see the member within 15 business days of receiving the request.
- A copy of the medical records and/or results of the visit should be sent to PCP office also to allow continuity of care.

In some cases, a member may self-refer to a specialist. These cases include but are not limited to:

- Family planning and evaluation
- Diagnosis, treatment and follow-up of sexually transmitted diseases (STDs)

Please note: Specialists are responsible for ensuring that necessary pre-authorizations have been obtained prior to providing services.

For some medical conditions, it makes sense for the specialist to **be** the PCP. Members may request that the specialist be assigned as their PCP if:

- The member has a chronic illness
- The member has a disabling condition
- The member is a child with special health care needs

OFFICE HOURS

To maintain continuity of care, providers are required to be available to provide services for a minimum of **24 hours each week**. Office hours must be clearly posted and members must be informed about the provider's availability at each site. There are strict guidelines for providing access to health care **24 hours a day, 7 days a week**:

- Providers must be available 24 hours a day by telephone.
- During those times when a provider is not available, an on-call provider must be available to take calls.

WAIT TIMES

When a provider's office receives a call from an Anthem Blue Cross member during regular business hours for assistance and possible triage, the provider or another health care professional must either take the call or call the member back within 30 minutes of the initial call.

NONDISCRIMINATION STATEMENT

Providers must post a statement in their offices that details hours of operation that do not discriminate against Anthem Blue Cross members. This includes wait times for the following:

- Waiting times for appointments
- Waiting times for care at facilities
- Languages spoken

AFTER-HOURS SERVICES

It is The Anthem Blue Cross policy and the state of California's requirement that our members have access to quality health care services 24 hours a day, 7 days a week. That kind of access means our PCPs must have a system in place to ensure that members can call after hours with medical questions or concerns.

We monitor PCP compliance with after-hours access standards on a regular basis. It is recommended that PCPs advise their answering services to participate in any after-hours monitoring. Failure to comply may result in corrective action.

PCPs must adhere to the following after-hours protocols:

- Forward member calls directly to the PCP or on-call provider or instruct the member that the provider will contact the member **within 30 minutes**.
- Ask the member if the call is an emergency. In the event of an emergency, they must immediately direct the member to **dial 911** or proceed directly to the nearest hospital emergency room.
- Have the ability to contact a telephone interpreter for members with language barriers.
- Return all calls.

Answering machine messages:

- May be used in the event that staff or an answering service is not immediately available.
- Must instruct members with emergency health care needs to **dial 911** or proceed directly to the nearest hospital emergency room.
- Must provide instructions on how to contact the PCP or on-call provider in a nonemergency situation.
- Must provide instructions in English, Spanish and any other language appropriate to the PCP's practice.

We offer the following suggested text for answering machines:

"Hello, you have reached [insert physician office name]. If this is an emergency, hang up and dial 911 or go to the nearest hospital emergency room. If this is not an emergency and you have a medical concern or question, please call [insert contact phone or pager number]. You will receive a return call from the on-call physician within [time frame]."

Please note: Anthem Blue Cross prefers that PCPs use an in-network provider for on-call services. When that is not possible, PCPs must use their best efforts to help ensure that the covering on-call provider abides by the terms of the Anthem Blue Cross provider contract.

INTERACTIVE VOICE RESPONSE REQUIREMENTS OF PROVIDERS

The following providers are required to have 24-hour service:

- Assisted living facilities/services
- Emergency response systems
- Nursing homes/skilled nursing facilities

Such providers will provide advice and assess care as appropriate for each member's medical condition. Emergent conditions will be referred to the nearest emergency room.

REQUIRED ASSESSMENTS

The **initial health assessment** (IHA) is a complete medical history, head-to-toe physical examination and assessment of health behaviors.

The IHA should include but is not limited to the following specific screenings:

- A comprehensive history
- Past medical history
- Preventive services
- Comprehensive physical exam
- Diagnoses and plan of care
- Staying Healthy Assessment (SHA) including the Individual Health Education Behavioral Assessment (IHEBA)
- Developmental and behavioral assessment
- Vaccines as recommended by the ACIP

PCPs are strongly encouraged to review their monthly eligibility list available on the Anthem Blue Cross provider portal and to proactively contact

their assigned members to make an appointment for an IHA within the following time frame:

- All new members must have an IHA within 120 days of enrollment.

The PCP's office is responsible for making and documenting all attempts to contact assigned members. Members' medical records must reflect the reason for any delays in performing the IHA including any refusals by the member to have the exam.

An initial health assessment is **not** necessary under the following conditions:

- If the new member is an existing patient of the PCP (but new to us) with an established medical record showing baseline health status. This record must include a documented IHA within the past 12 months prior to the member's enrollment and sufficient information for the PCP to provide treatment.
- If the new member is not an existing patient, transferred medical records can also meet the requirements for an IHA if a completed health history is included.
- If the new member refuses to schedule an IHA. The refusal must be documented in the member's medical record.

SENIORS AND PERSONS WITH DISABILITIES HEALTH RISK ASSESSMENT (SPD HRA)

We strongly encourage provider is assisting members in completing the health risk assessment for Senior and Persons with Disabilities. The assessment is a ten-minute survey. The assessment is state requirement. This information is private. Information collected in the health survey ensures members get the most out of their health plan.

The SPD HRA assist with identifying care coordination needs. For example, if member needs assistance with coordinating specialty services, we will help schedule an exam with a specialty provider. Or, if you member has to refill a prescription, we can assist the member with navigating their pharmacy benefits. These are just a few of many services Anthem can assist you with. We help our members stay connected to care and prevent unnecessary emergency room visits or hospitalizations. Staying Healthy Assessment Tool (Medi-Cal Only)

In addition to the initial health assessment, providers working with Medi-Cal members must also fill out the Staying Healthy Assessment (SHA) Tool and periodically readminister it according to the SHA periodicity chart. Annual reviews of existing SHAs and counseling are required at subsequent periodic exams.

Note: This requirement does not apply to Major Risk Medical Insurance Program members.

The California Department of Health Care Services (DHCS) recently updated the SHA and Individual Health Education Behavioral Assessment (IHEBA). It is now available in seven age-specific pediatric questionnaires and two adult questionnaires including one designed for seniors. It was developed to achieve the following:

- Identify and track high-risk behaviors
- Prioritize patient health education needs
- Initiate discussion and counseling on prioritized high-risk behaviors related to lifestyle, behavior, environment, cultural and language

PCP responsibilities for the **Staying Healthy Assessment Program** include:

- Reviewing the completed SHA with the patient.
- Exploring patient responses to verify risk factors and determining the extent to which they might harm the patient's health.
- Based upon a patient's behavioral risks and willingness to make lifestyle changes, PCPs should provide tailored health education counseling, intervention, referral and follow-up.
- The PCP must document, initial and date all health education interventions and referrals

using the intervention codes listed on the bottom of each SHA tool.

Newly added PCP responsibilities for the Staying Healthy Assessment Program include:

- Receive training on implementing and administering the new SHA
- Attest to receiving training on the implementation, administration and state regulations regarding the use of the new SHA assessment forms
- Complete the DHCS-approved provider presentation training online at the following link:

  http://tinyurl.com/StayingHealthy2014

  (If the slideshow does not start when opening the PowerPoint file, select the **Slide Show** tab and select the **From Beginning**" icon in the top left-hand corner of your screen to start the narrated training.)

To Obtain SHA Assessment Forms

The SHA assessment forms in all the age categories and most Medi-Cal threshold languages are posted on the DHCS SHA webpage and are available to download at the following link:

www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx

To request hard copies of the SHA assessment forms including electronic versions of the assessment forms in Farsi or Khmer, please contact your local regional health plan.

Electronic SHA Formats

With many offices now using electronic medical records (EMRs), providers have several options for using an electronic format of the SHA.

DHCS requires that providers must complete and submit either the SHA Electronic or Other Format Notification Form or Use of Bright Futures Notification Form at least one month prior to implementation. Providers are advised to contact a local regional health plan representative to request this form and initiate the process.

USE OF ALTERNATIVE IHEBA TOOLS

Anthem Blue Cross strongly encourages the use of the SHA. Should you prefer to use and administer an alternative IHEBA, a request and justification to do so must be submitted to Anthem Blue Cross two months in advance of scheduled implementation to receive approval.

For more information about the SHA, please contact your local Provider Relations team at the appropriate phone numbers listed in the **Quick Reference** chapter of this manual.

CALIFORNIA CHILDREN'S SERVICES

California Children's Services (CCS) is a state program that treats children under 21 years of age with certain health conditions, diseases or chronic health problems and who meet the CCS program rules. If this health plan or your PCP believes a child has a CCS condition, he or she will be referred to the CCS program.

CCS program staff will decide if the child is eligible for CCS services. If the child can get these types of care, CCS providers will treat him or her for the CCS condition. This health plan will continue to cover types of service that do not have to do with the CCS condition such as physicals, vaccines and well-child checkups.

Anthem Blue Cross does not cover care given by the CCS program. For CCS to cover these problems, CCS must approve the provider, services and equipment. The state (**not** Anthem Blue Cross) pays for CCS services.

CCS does not cover all problems. CCS covers most problems that physically disable or that need to be treated with medicines, surgery or rehabilitation (rehab).

CCS covers children with problems such as:

- Congenital heart disease
- Cancers
- Tumors
- Hemophilia
- Sickle cell anemia
- Thyroid problems
- Diabetes
- Serious chronic kidney problems
- Liver disease
- Intestinal disease
- Cleft lip/palate
- Spina bifida
- Hearing loss
- Cataracts
- Cerebral palsy
- Seizures that are not controlled
- Rheumatoid arthritis
- Muscular dystrophy
- AIDS
- Severe head, brain or spinal cord injuries
- Severe burns
- Severely crooked teeth

Approved CCS providers must submit claims on the appropriate form to the local CCS program according to the terms of their CCS agreement. CCS is the primary payer for CCS-eligible diagnosis; Anthem Blue Cross does not provide authorization for those conditions.

All providers, both in- and out-of-network, are obligated to follow CCS guidelines including the following:

- Refer CCS-eligible or potentially eligible conditions to CCS and Anthem Blue Cross within 24 hours or the next business day.
- Use CCS network physicians and hospitals. Non-CCS-paneled hospitals must contact CCS immediately for authorization of inpatient members who are not stable for transfer to a CCS-paneled hospital.

Anthem Blue Cross will not reimburse claims for CCS-eligible conditions denied by CCS for noncompliance with CCS program requirements. In addition, providers may not seek additional payment or compensation from members for any of the following:

- CCS-covered services
- CCS-denied claims due to failure to submit the application within CCS time frames
- CCS-denied claims due to failure to use CCS network physicians or hospitals

Anthem Blue Cross will reimburse for all health care services unrelated to the CCS-covered condition. We do not reimburse for services related to a potentially medically eligible condition or for care that is related to a condition that has been qualified by the local CCS program.

PREGNANCY NOTIFICATION

https://mediproviders.anthem.com/ca/pages/prenatal-resources.aspx

Fax number: **1-855-410-4451**

The pregnancy notification process identifies Anthem Blue Cross members who are covered by Medi-Cal Managed Care (Medi-Cal) early in their pregnancy. Our goal is to identify women who may need additional health education, transportation assistance, case management (including high-risk obstetrics), care coordination and any other needs related to women's health.

The *Pregnancy Notification Form* provides important information to Anthem Blue Cross so that we can ensure pregnant members access prenatal care timely within their first trimester or within 42 days of enrollment as recommended by NCQA.

There is a revised *Pregnancy Notification Form* effective February 1, 2017, that replaces all prior versions. It can be found on the Anthem Blue Cross provider website located in the *Prenatal Toolkit* link at the beginning of this section.

MEDICAL RECORDS

Medical records must be maintained in a manner that ensures effective and confidential member

care and quality review. At Anthem Blue Cross, we perform medical record reviews upon signing a provider contract and, at minimum, every three years thereafter to ensure providers are in compliance with these standards.

Medical records must be stored and retrieved in a manner that protects patient information according to the Confidentiality of Medical Information Act. This act prohibits a provider of health care from disclosing any individually identifiable information regarding a patient's medical history, treatment, or behavioral and physical condition without the patient's or legal representative's consent or specific legal authority.

Records required through a legal instrument may be released without patient or patient representative consent if in compliance with law. Providers must be familiar with the security requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and be in compliance.

In addition, providers must provide access to medical records for the following:

- Medical record reviews by Anthem Blue Cross or the provider's contracted External Quality Review Organization (EQRO). Providers must have procedures in place to provide timely access to medical records in the providers' absence.
- For public health communicable disease reporting, providers must provide all medical records or information as requested and in the time frame established by state and federal laws.

PREVENTIVE HEALTH CARE

Current educational materials and health management programs are located on the Quality Improvement Programs website below:

https://mediproviders.anthem.com/ca/pages/quality-improvement-program.aspx

With respect to the issue of coverage, each member should review his/her Evidence of Coverage for details concerning benefits, procedures and exclusions prior to receiving treatment.

The Evidence of Coverage supersedes the preventive health guideline recommendations.

Note: Our recommendation of these guidelines is not an authorization, certification, explanation of benefits or a contract. Actual member benefits and eligibility are determined in accordance with the requirements set forth by the state of California. With respect to the issue of coverage, each member should review his/her Evidence of Coverage for details concerning benefits, procedures and exclusions prior to receiving treatment. The Evidence of Coverage supersedes the preventive health guideline recommendations.

PREVENTIVE HEALTH CARE GUIDELINES

The most up-to-date *Preventive Health Care Guidelines* are located on our website at:

https://mediproviders.anthem.com/ca/pages/preventive-healthcare-guidelines.aspx

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

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

CLINICAL PRACTICE GUIDELINES

Several national organizations produce guidelines for asthma, diabetes, hypertension and other conditions. The guidelines, which Anthem Blue Cross uses for quality and disease management programs, are based on reasonable medical evidence. We review the guidelines at least every two years or when changes are made to national guidelines for content accuracy, current primary sources, new technological advances and recent medical research.

Clinical Practice Guidelines can be downloaded at:

- **https://mediproviders.anthem.com/ca/pages/quality-improvement-program.aspx**
- **Behavioral health: https://mediproviders.anthem.com/ca/pages/clinical-practice-guidelines.aspx**
- **Matrix: https://mediproviders.anthem.com/Documents/CACA_CAID_ClinicalPracticeGuidelinesMatrix.pdf**

☎ You can also call Provider Services at **1-866-231-0847** to receive a copy.

COMPREHENSIVE PERINATAL SERVICES PROGRAM

The **Comprehensive Perinatal Services Program** (CPSP) is a Medi-Cal program that provides individualized perinatal services during pregnancy and 60 days following delivery by or under the personal supervision of a physician approved by CPSP. All members must be offered CPSP services.

The program emphasizes nutritional services, psychosocial support, health education and postpartum treatment and intervention.

PCPs caring for pregnant women and obstetrics/gynecology specialists are responsible for assessing member needs and referring all pregnant members to the following:

- Community prenatal services
- Women, Infants and Children Program (WIC)
- Substance abuse programs
- Prenatal education classes

Women should be referred to a CPSP provider by calling the appropriate Customer Care Center at the numbers listed at the beginning of this chapter.

IMMUNIZATION PROGRAM

The **Immunization Program** was designed to increase both childhood immunization rates and the number of members who are fully immunized.

ACIP has recommended immunizations for all children as well as adult members.

All members should be notified by the PCP of the use of the California Immunization Registry (CAIR) to monitor immunizations administered to all members. This program allows members to receive the appropriate immunization based on age at the appropriate timeframe.

Providers should be working with the CAIR program so all immunization information is obtained by CAIR whether by inputting data, upload or transfer of information.

When immunizations are given, the PCP must also distribute the Vaccine Information Statement (VIS) that educates on the vaccines administered.

ALL PEDIATRIC PROVIDERS MUST PARTICIPATE IN THE VACCINES FOR CHILDREN (VFC) PROGRAM. WELL WOMAN

The **Well Woman Program** was developed to remind and encourage women to have regular cervical and breast cancer screenings. The Well Woman Reminder Program sends a screening test reminder mailer to women who are not up-to-date with their recommended cervical and/or breast cancer screenings.

Providers are encouraged to refer members for screenings and/or schedule the exams. PCP

responsibilities for the care of female members include:

- Educating members on Preventive Health Care Guidelines for women
- Referring members for cervical and breast cancer screenings
- Scheduling screening exams for members

CHILDHOOD LEAD EXPOSURE TESTING/FREE BLOOD TEST KITS

CMS requires that all children enrolled in Medicaid be tested for lead exposure at 1 and 2 years of age. Children from 3 to 6 years of age who have not been tested also need screening regardless of their risk factors.

PCP doing Point-of-Care testing must also notify the California Department of Public Health (CDPH) of the results of the test. If testing is in a laboratory, they also must report 100% of all results.

Note: Completion of a lead risk assessment questionnaire does not fulfill this screening requirement; a blood draw is also required.

BREASTFEEDING

The American Academy of Pediatrics, the American College of Obstetrics and Gynecology, and the American Public Health Association recognize breastfeeding as the preferred method of infant feeding. Providers should encourage breastfeeding for all pregnant women unless it is not medically appropriate.

To support this goal, providers should do the following:

- Refer pregnant and postpartum women to our Breastfeeding Support Line at **1-800-231-2999** for information, support and referrals.
- Refer pregnant women to community resources that support breastfeeding such as La Leche League, WIC and breastfeeding classes.
- Assess all pregnant women for health risks that are contraindications to breastfeeding (for example, AIDS and active tuberculosis).
- Provide breastfeeding counseling and support to postpartum women immediately after delivery.
- Assess postpartum women to determine the need for lactation durable medical equipment (DME) such as breast pumps and breast pump kits.
- Document all referrals and treatments related to breastfeeding in the patient's medical record (pediatricians should document frequency and duration of breastfeeding in baby's medical record).
- Refer members to breastfeeding classes prior to delivery by calling our Customer Care Center.
- Support continued breastfeeding at the postpartum visit.

Lactation management aids are a covered benefit for Medi-Cal members. Members can obtain hand-held breast pumps through a prescription without prior authorization. In addition, the following services are available:

- Electric breast pumps are available for members with medical necessity with a provider referral and prior authorization. Contact Utilization Management for more information.
- Arrangement for the provision of human milk for newborns must be made if the mother is unable to breastfeed due to medical reasons and/or the infant cannot tolerate or has medical contraindications to the use of any formula including elemental formulas. The **Mother's Milk Bank of Santa Clara Valley Medical Center** is the only human milk bank in the state of California. They can be contacted at:

☎ **1-408-998-4550**

CONTRACT TERMINATION WITH HEALTH PLAN

When a participating provider notifies Anthem Blue Cross that the provider is terminating the contract with the network, we notify all members that the provider will no longer be available. A terminating provider who is actively treating members must continue to treat members until the provider's date of termination.

Impacted members are notified about the termination and provided the following information:

- The impending termination date of their provider
- Their right to request continued access to care
- Contact information to request a PCP change
- The DHCS Ombudsman phone number
- Referrals to Utilization Management for continued access to care consideration
- The opportunity to choose a new PCP or be assigned to a new PCP with the option to change if the member does not choose a PCP
- All other notification language required by the H&S Code and the DHCS All Plan Letter, Medi-Cal provider and subcontract suspensions, terminations and decertifications

Members under the care of specialists can also submit requests for continued access to care including continued care after the transition period by calling the appropriate Medi-Cal Customer Care Center below:

☎ **1-800-407-4627** or **1-888-757-6034** (TTY)
Outside L.A. County

☎ **1-888-285-7801** or **1-888-757-6034** (TTY)
Inside L.A. County

TERMINATION OR AFFILIATION CHANGE WITH PROVIDER GROUPS

Anthem Blue Cross PCPs may have multiple provider medical group (PMG) affiliations. To ensure continuity of care, membership will remain with an assigned PCP unless the PCP does not have another Anthem Blue Cross PMG affiliation.

A PCP can change PMG affiliations. Assigned members will transfer to follow the PCP under the new affiliation. The following exceptions to this policy shall occur:

- If the PCP is an employee of the PMG (except Los Angeles), member affiliation will remain with the PMG. Members may elect to change this PMG affiliation to the PCP's new affiliation in order to facilitate continued care under the established PCP.
    - If the PCP has an active PMG affiliation with Care 1st or LA Care outside of Anthem Blue Cross, members will be transitioned to the active health plan.
- If a member is assigned to a safety net clinic, the member's affiliation remains with the clinic should a PCP terminate its affiliation.

CONTINUITY OF CARE PROVISION FOR A PMG-EMPLOYED PHYSICIAN

If the PMG does not have the appropriate PCP specialty to serve members that were assigned to a departing employed physician, Anthem Blue Cross has the right to move the affected member to the PCP's new PMG affiliation or an appropriate PMG.

For example: If the only pediatrician affiliated with the PMG terminates his employment or his employment is terminated, Anthem Blue Cross will move members to an alternate PMG affiliation to ensure the affected members have access to appropriate pediatric care. If the PCP changes PMG affiliation and relocates his practice further than 10 miles, Anthem Blue Cross also has the right to select a new PCP for the affected membership.

Network education representatives (NERs) are the primary account managers for all provider services associated with an assigned PMG. The NERs also serve as liaisons between Anthem Blue Cross and the provider network for many providers who exist outside of the PMG including hospital, ancillary and individual providers.

The NER is responsible for coordinating all additions, changes and terminations from the PCP and PMG.

PROVIDER TERMINATIONS FROM GROUPS

When a provider who is part of a PMG and/or an independent practice association (IPA) decides to terminate from the Anthem Blue Cross network, the following guidelines must be followed:

- The provider should notify all affiliated PMGs/IPAs within a minimum of 120 days to ensure member notifications can be sent timely.
- The PMGs/IPAs should notify Anthem Blue Cross. The provider's termination will become effective 120 days after we receive notification.
- The provider's decision to terminate from Anthem Blue Cross could impact participation in other Anthem Blue Cross lines of business and may prevent the provider from participating with us in the future.

Note: If we determine that the quality of care or services provided by a health care professional is not satisfactory as evidenced by member satisfaction surveys, member complaints or grievances, utilization management data, complaints or lawsuits alleging professional negligence, or any other quality of care indicators, Anthem Blue Cross may terminate the Provider Agreement.

UPDATING PROVIDER DIRECTORIES

Anthem providers are required to inform us of any material changes to their practice, either through voluntarily effort or through mandatory response to Anthem Blue Cross provider outreach efforts in compliance with Senate Bill 137 (SB137) including:

- Change in professional business ownership
- Change in business address or the location where services are provided
- Change in federal 9-digit Tax Identification Number (TIN)
- Change in specialty
- The age range of patients serviced by the provider
- Languages spoken by both provider and mid-level staff
- Change in demographic data (for example: phone numbers, fax numbers, email address, handicap or ADA accessibility and office hours)
- Hospital admitting privileges
- Legal or governmental action initiated against a health care professional including but not limited to: an action for professional negligence, for violation of the law, or against any license or accreditation which, if successful, would impair the ability of the health care professional to carry out the duties and obligations under the Provider Agreement
- Other problems or situations that impair the ability of the health care professional to carry out the duties and obligations under the Provider Agreement care review and grievance resolution procedures
- Notification that the provider is accepting new patients

Failure to respond within the designated time frame indicated on the outreach form **will result in suppression from the provider directory**.

Submissions provided voluntarily unrelated to the SB137 outreach do not satisfy this requirement. There must be a response to the SB137 outreach form.

UPDATING PROVIDER INFORMATION

For voluntary updates separate from the SB137 outreach, use the new online *Provider Maintenance Form (PMF)* to notify Anthem Blue Cross of changes. The form is available in the **Forms Library > General Forms** on the *Provider Resources* page of our website at:

https://mediproviders.anthem.com/ca/pages/forms.aspx

For directions on how to access the ProviderAccess page of our website, please see **Chapter 2** of this manual.

CREDENTIALING SCOPE

Anthem Blue Cross credentials the following 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 are state certified or licensed and have doctoral or master's level training
- Clinical social workers who are state certified or state licensed and have master's level training
- Psychiatric nurse practitioners who are nationally or state certified or state licensed or behavioral nurse specialists with master's level training
- Other behavioral health care specialists who are licensed, certified or registered by the state to practice independently
- Telemedicine practitioners who have an independent relationship with Anthem Blue Cross and who provide treatment services under the health benefits plan
- Medical therapists (e.g., physical therapists, speech therapists and occupational therapists)
- Licensed genetic counselors who are licensed by the state to practice independently
- Audiologists who are licensed by the state to practice independently
- Acupuncturists (non-medical doctors or doctors of osteopathic medicine) who are licensed, certified or registered by the state to practice independently
- Nurse practitioners who are licensed, certified or registered by the state to practice independently
- Certified nurse midwives who are licensed, certified or registered by the state to practice independently
- Physician assistants (as required locally)

Anthem Blue Cross also certifies the following behavioral health practitioners (including verification of licensure by the applicable state licensing board to independently provide behavioral health services):

- Certified behavioral analysts
- Certified addiction counselors
- Substance abuse practitioners

Anthem Blue Cross credentials the following health delivery organizations (HDOs):

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Nursing homes
- Free-standing surgical centers
- Birthing centers
- Convenient care centers/retail health clinics
- Intermediate care facilities
- Urgent care centers
- Federally qualified health centers (FQHC)
- Home infusion therapy agencies
- Rural health clinics
- 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

The following HDOs are not subject to professional conduct and competence review under the Anthem Blue Cross credentialing program but are subject to a certification requirement process:

- 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

INITIAL CREDENTIALING

Each practitioner or HDO must complete a standard application form when applying for initial participation in one or more of The Anthem Blue Cross networks or plan programs. This application may be a state-mandated form or a standard form created by or deemed acceptable by Anthem Blue Cross.

For practitioners, the Council for Affordable Quality Healthcare (CAQH), a universal credentialing datasource, is utilized. CAQH built the first national provider credentialing database system which is designed to eliminate the duplicate collection and updating of provider information for health plans, hospitals and practitioners.

To learn more about CAQH, visit their website at **www.CAQH.org**.

Anthem Blue Cross 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 Credentials Committee (CC) making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, Anthem Blue Cross 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.

Practitioners
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 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.
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

HDOs
Accreditation if applicable
License to practice if applicable
Malpractice insurance
Medicare certification if applicable
Department of Health survey results or recognized accrediting organization certification
License sanctions or limitations if applicable
Medicare, Medicaid or FEHBP sanctions

RECREDENTIALING

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

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

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

HEALTH DELIVERY ORGANIZATIONS

New HDO applicants will submit a standardized application to Anthem Blue Cross for review. If the candidate meets Anthem Blue Cross 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 Blue Cross 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 Blue Cross may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or a site survey performed by a designated independent external entity within the past 36 months for that HDO.

Recredentialing of HDOs occurs every three 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 Blue Cross 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.

HDO ELIGIBILITY CRITERIA

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Anthem Blue Cross 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. Nonaccredited 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 Blue Cross 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 Blue Cross standards.

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 Blue Cross 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 Anthem Blue Cross other credentialed provider network(s).
4. Liability insurance acceptable to Anthem Blue Cross.
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 Blue Cross quality and certification criteria standards have been met.

ADDITIONAL PARTICIPATION CRITERIA FOR HDO BY PROVIDER TYPE

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
Clinical laboratories	CLIA, COLA
Convenient care centers (CCCs)/retail health clinics (RHC)	DNV/NIAHO, UCAOA
Dialysis center	TJC, CMS
Federally qualified health center (FQHC)	AAAHC
Free-standing surgical centers	AAAASF, AAPSF, HFAP, IMQ, TJC
Home health care agencies (HHA)	ACHC, CHAP, CTEAM , DNV/NIAHO, TJC
Home infusion therapy (HIT)	ACHC, CHAP, CTEAM, HQAA, TJC
Hospice	ACHC, CHAP, TJC
Intermediate care facilities	CTEAM
Portable X-ray suppliers	FDA certification
Skilled nursing facilities/nursing homes	BOC INT'L, CARF, TJC
Rural health clinic (RHC)	AAAASF, CTEAM, TJC
Urgent care center (UCC)	AAAHC, IMQ, TJC, UCAOA, NUCCA

Facility Type — Behavioral Health Care	Acceptable Accrediting Agencies
Acute care hospital — psychiatric disorders	CTEAM, DNV/NIAHO, TJC, HFAP
Acute inpatient hospital — chemical dependency/detoxification and rehabilitation	HFAP, NIAHO, TJC
Adult family care homes (AFCH)	ACHC, TJC
Adult foster care	ACHC, TJC
Community mental health centers (CMHC)	AAAHC, TJC
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
Partial hospitalization/day treatment — psychiatric disorders and/or substance abuse	CARF, DNV/NIAHO, HFAP, TJC, for programs associated with an acute care facility or residential treatment facilities
Residential treatment centers (RTC) — psychiatric disorders and/or substance abuse	DNV/NIAHO, TJC, HFAP, CARF, COA

Facility Type — Rehabilitation	Acceptable Accrediting Agencies
Acute inpatient hospital — detoxification only facilities	DNV/NIAHO, HFAP, TJC
Behavioral health ambulatory detox	CARF, TJC
Methadone maintenance clinic	CARF, TJC
Outpatient substance abuse clinics	CARF, COA, TJC

CREDENTIALING PROGRAM STANDARDS

ELIGIBILITY CRITERIA

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
2. Possess a current, valid, unencumbered, unrestricted and nonprobationary license in the state(s) where he/she provides services to covered individuals
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:

1. For MDs, DOs, DPMs, and oral and maxillofacial surgeons, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties [ABMS], American Osteopathic Association [AOA], Royal College of Physicians and Surgeons of Canada [RCPSC], College of Family Physicians of Canada [CFPC], American Board of Podiatric Surgery [ABPS], American Board of Podiatric Medicine [ABPM], or American Board of Oral and Maxillofacial Surgery [ABOMS]) in the clinical discipline for which they are applying.
2. Individuals will be granted five years or a period of time consistent with ABMS board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
3. Individuals with board certification from the American Board of Podiatric Medicine will be granted five years after the completion of their residency to meet this requirement. Individuals with board certification from the American Board of Foot and Ankle Surgery will be granted seven years after completion of their residency to meet this requirement.
4. However, individuals no longer eligible for board certification are not eligible for continued exception to this requirement.

As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:

1. Previous board certification (as defined by one of the following: ABMS, AOA, RCPSC, CFPC) in the clinical specialty or subspecialty for which they are applying which has now expired and a minimum of 10 consecutive years of clinical practice
2. 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
3. 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 Blue Cross network and the applicant's professional activities are spent at that institution at least 50% of the time.

Practitioners meeting one of these three above alternative criteria will be viewed as meeting all Anthem Blue Cross 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 Blue Cross review and approval. Reports submitted by delegate to Anthem Blue Cross must contain sufficient documentation to support the above alternatives, as determined by Anthem Blue Cross.

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

CRITERIA FOR SELECTING PRACTITIONERS

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations
2. Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote
3. Primary source verifications within acceptable time frames 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.

DEA/CDS

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:

1. It can be verified that this application is pending.
2. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained.
3. The applicant agrees to notify Anthem Blue Cross upon receipt of the required DEA/CDS registration.

4. Anthem Blue Cross will verify the appropriate DEA/CDS registration via standard sources.
    - The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90 calendar day time frame will result in termination from the network.

DEA/CDS — OUT OF STATE

Initial applicants who possess a DEA/CDS registration in a state other than the state in which they will be treating covered individuals will be notified of the need to obtain the additional DEA/CDS registration.

If the applicant has applied for additional DEA/CDS registration, the credentialing process may proceed if **all** of the following criteria are met:

1. It can be verified that this application is pending.
2. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained.
3. The applicant agrees to notify Anthem Blue Cross upon receipt of the required DEA/CDS registration.
4. **Note**: Anthem Blue Cross will verify the appropriate DEA/CDS registration via standard sources; applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90 calendar day time frame will result in termination from the network.
5. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP.
6. No current hospital membership or privilege restrictions and no history of hospital membership or privilege restrictions.
7. No history of or current use of illegal drugs or history of or current alcoholism.
8. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
9. 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. Other gaps in work history of 6 to 24 months will be reviewed by the Chair of the CC and may be presented to the CC if the gap raises concerns of future substandard professional conduct and competence. In the absence of this concern the Chair of the CC may approve work history gaps of up to two years.
10. No history of criminal/felony convictions or a plea of no contest.
11. A minimum of the past 10 years of malpractice case history is reviewed.
12. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in The Anthem Blue Cross 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.
13. No involuntary terminations from an HMO or PPO.
14. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
    - Investment or business interest in ancillary services, equipment or supplies
    - 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

- An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria
- 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)
- 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
- Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion
- History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction

Note: The CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants. Practitioners who meet all participation criteria for initial or continued participation and whose credentials have been satisfactorily verified by the Credentialing department may be approved by the Chair of the CC after review of the applicable credentialing or recredentialing information. This information may be in summary form and must include, at a minimum, practitioner's name and specialty.

1. Submission of complete recredentialing application and required attachments that must not contain intentional misrepresentations
2. Recredentialing application signed date within 180 calendar days of the date of submission to the CC for a vote
3. Primary source verifications within acceptable time frames 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 recredentialing application
5. Currently participating providers 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 Blue Cross 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 Anthem Blue Cross other credentialed provider network(s); special consideration regarding the practitioner's continued participation in The Anthem Blue Cross other credentialed practitioner network(s) may be requested by the Vice President (VP) responsible for that network(s) if, in the opinion of the requesting VP, the following criteria are met: the federal sanction, debarment or exclusion is not reflective of significant issues of professional conduct and competence, and participation of the practitioner is important for network adequacy; the request with supporting information will be brought to The Anthem Blue Cross geographic Credentials Committee for consideration and final determination, without practitioner appeal rights related to the special consideration, regarding the practitioner's continued participation in The Anthem Blue Cross other credentialed provider network(s), if such participation would be permitted under applicable state regulation, rule or contract requirements

6. Current, valid, unrestricted license to practice in each state in which the practitioner provides care to covered individuals
7. *No current license probation
8. *License is unencumbered
9. No new history of licensing board reprimand since prior credentialing review
10. *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)
11. Current DEA/CDS registration and/or state controlled substance certification without new (since prior credentialing review) history of or current restrictions
12. 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
13. No new (since previous credentialing review) history of or current use of illegal drugs or alcoholism
14. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field
15. No new (since previous credentialing review) history of criminal/felony convictions including a plea of no contest
16. 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
17. No new (since previous credentialing review) involuntary terminations from an HMO or PPO
18. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
    - Investment or business interest in ancillary services, equipment or supplies
    - 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
    - An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria
    - 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)
    - 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
    - Actions taken by a hospital against a practitioner's privileges related

solely to the failure to complete medical records in a timely fashion

- History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction

19. No QI data or other performance data including complaints above the set threshold
20. Recredentialed at least every three years to assess the practitioner's continued compliance with Anthem Blue Cross 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.

PARTICIPATION CRITERIA FOR BEHAVIORAL HEALTH PRACTITIONERS

LICENSED CLINICAL SOCIAL WORKERS (LCSW) OR OTHER MASTER LEVEL SOCIAL WORK LICENSE TYPE:

- 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 years of the time the practitioner graduated
- Full accreditation is required; candidacy programs will not be considered 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:

- 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
- Master or doctoral degrees in divinity do not meet criteria as a related field of study
- 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

- 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

CLINICAL NURSE SPECIALIST/PSYCHIATRIC AND MENTAL HEALTH NURSE PRACTITIONER:

- 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
- 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
- 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
- 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:

- Valid state clinical psychologist license
- 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
- 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
- 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:

- Must meet all the criteria for a clinical psychologist listed above and be board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN).
- A practitioner credentialed by the National Register of Health Service Providers in Psychology with an area of expertise in neuropsychology may be considered.
- 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:
    - Transcript of applicable pre-doctoral training

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

LICENSED PSYCHOANALYSTS:

- Applies only to practitioners in states that license psychoanalysts.
- Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Credentialing Policy (e.g. psychiatrist, clinical psychologist, licensed clinical social worker).
- Practitioner must possess a valid psychoanalysis state license.
  - 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.
  - 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.

Note: 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.

Must meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state and examination requirements for licensure as determined by the licensing state.

ADDITIONAL PARTICIPATION CRITERIA

NURSE PRACTITIONERS:

- 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.
- 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 an 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.

- 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.
- 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.
- All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
    - Certification program of the American Nurse Credentialing Center (**www.nursecredentialing.org**), a subsidiary of the American Nursing Association (**www.nursingcertification.org/exam_programs.htm**)
    - American Academy of Nurse Practitioners — Certification Program (**www.aanpcertification.org**)
    - National Certification Corporation (**www.nccwebsite.org**)
    - Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner (CPN) (Note: CPN is not a nurse practitioner.) (**www.pncb.org/ptistore/control/exams/ac/progs**)
    - Oncology Nursing Certification Corporation (ONCC) — Advanced Oncology Certified Nurse Practitioner (AOCNP) — only (**http://oncc.org**)

Note: 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.

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.

The NP applicant will undergo the standard credentialing processes outlined in Credentialing Policies #4-17. 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.

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.

NPs will be clearly identified as such:

1. On the credentialing file
2. At presentation to the Credentialing Committee
3. On notification to network services and to the provider database

CERTIFIED NURSE MIDWIVES:

- 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.

- The required education/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.
- 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.
- 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.
- All CNM applicants will be certified by one of the following:
    - The National Certification Corporation for OB/GYN and Neonatal Nursing
    - The American Midwifery Certification Board, previously known as the American College of Nurse Midwifes

Note: 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.

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.

The CNM applicant will undergo the standard credentialing process outlined in Credentialing Policies #4-16. 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.

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.

CNMs will be clearly identified as such:

1. On the credentialing file
2. At presentation to the Credentialing Committee
3. On notification to network services and to the provider database

PHYSICIAN ASSISTANTS:

- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- The PA applicant will undergo the standard credentialing process outlined in Credentialing Policies #4-16. 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.
- 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.
- PA's will be clearly identified such:

1. On the credentialing file
2. At presentation to the Credentialing Committee
3. On notification to network services and to the provider database

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 Blue Cross 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 Blue Cross medical director designee and the Vice Chair must be a lead medical officer or an Anthem Blue Cross medical director designee for that line of business not represented by the chair. In states or regions where only one line of business is represented, the Chair of the CC will designate a Vice Chair for that line of business also represented by the Chair.

The CC will include at least five but no more than ten external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics; obstetrics/gynecology; adult medicine [family medicine or internal medicine]; surgery; behavioral health; with the option of using other specialties when needed as determined by the Chair/Vice Chair).

CC membership may also include one to two other types of credentialed health providers (e.g., nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per Chair/Vice Chair's discretion. At least two of the physician committee members must be credentialed for each line of business (e.g., commercial, Medicare and Medicaid) offered within the geographic purview of the CC. The Chair/Vice Chair will serve as a voting member(s) and provide support to the credentialing/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. All CC meeting minutes and practitioner files are stored in locked cabinets and can only be seen by appropriate credentialing staff, medical directors and CC members. Documents in these files may not be reproduced or distributed except for confidential peer review and credentialing purposes, and peer review protected information will not be shared externally.

Practitioners and HDOs are notified that they have the right to review information submitted to support their credentialing applications. This right includes access to information obtained from any outside sources with the exception of references, recommendations or other peer review protected information.

Providers are given written notification of these rights in communications from Anthem Blue Cross which initiates the credentialing process. 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. Upon request, applicant will be provided with the status of his or her credentialing application. Written notification of this right may be included in a variety of communications from Anthem Blue Cross which includes the letter which initiates the credentialing process, the provider website or Provider Manual. When such requests are received, providers will be notified whether the credentialing application has been received, how far in the process it has progressed and a reasonable date for completion and notification. All such requests will be responded to verbally unless the provider requests a written response.

Anthem Blue Cross may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

NONDISCRIMINATION POLICY

Anthem Blue Cross will not discriminate against any applicant for participation in its networks or plan programs on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Anthem Blue Cross will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities that are provided to the covered individuals to meet their needs and preferences, this information is not required in the credentialing and recredentialing process. Determinations as to which practitioners/HDOs require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence as outlined in Anthem Blue Cross Credentialing Program Standards. CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process.

SANCTION MONITORING

To support certain credentialing standards between the recredentialing cycles, Anthem Blue Cross 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 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 Blue Cross 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 including but not limited to: review by the Chair of Anthem Blue Cross CC, review by the Anthem Blue Cross Medical Director, referral to the CC, or termination. Anthem Blue Cross credentialing departments will report practitioners or HDOs to the appropriate authorities as required by law.

APPEALS PROCESS

Anthem Blue Cross has established policies for monitoring and recredentialing practitioners and HDOs who seek continued participation in one or more of The Anthem Blue Cross 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 Blue Cross may wish to terminate practitioners or HDOs. Anthem Blue Cross 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 participation in The Anthem Blue Cross networks for professional competence and conduct reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB). Additionally, Anthem Blue Cross 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 Blue Cross 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 Blue Cross 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 suspension or loss of licensure, criminal conviction, or The Anthem Blue Cross determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to covered individuals. A practitioner/HDO whose license has been suspended or revoked has no right to informal review/reconsideration or formal appeal.

REPORTING REQUIREMENTS

When Anthem Blue Cross 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 Blue Cross may have an obligation to report such to the NPDB. Once Anthem Blue Cross receives a verification of the NPDB report, the verification report will be sent to the state licensing board. The credentialing staff will comply with all state and federal regulations in regard to the reporting of adverse determinations relating to professional conduct and competence. These reports will be made to the appropriate legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

AUTHORIZATION REQUESTS AND TIME FRAMES

☎ Medi-Cal Utilization Management: **1-888-831-2246**

☎ MRMIP Utilization Management: **1-877-273-4193**

☎ Hours of operation: Monday to Friday, 8 a.m. - 5 p.m.

ONLINE SUBMISSION

The Anthem Blue Cross Interactive Care Reviewer (ICR) is the preferred method for the submission of preauthorization requests. Providers can use the ICR to request inpatient and outpatient medical or behavioral health services for Anthem Blue Cross members. Providers can also use the ICR for inquiries on previously submitted requests regardless of how they were sent (phone, fax, ICR or other online tools).

The ICR features allow the provider to:

- Initiate preauthorization requests online, eliminating the need to fax. ICR allows detailed text, photo images and attachments to be submitted along with your request.
- Submit a notification of admission and request for continued stay review. ICR allows submission of justification and attachments along with your request.
- Make inquiries on previously submitted requests via phone, fax, ICR or other online tool.
- Have instant accessibility from almost anywhere including after business hours.
- Utilize the dashboard to provide a complete view of all UM requests with real-time status updates including email notifications if requested using a valid email address.
- Access real-time results for some common procedures with immediate decisions.

Note: For an optimal experience with the ICR, use a browser that supports 128-bit encryption. This includes Internet Explorer, Chrome, Firefox or Safari.

☎ To access ICR via the Availity Portal, visit: **www.availity.com**.

☎ Access ICR under *Authorizations and Referrals*.

☎ To register for an ICR training webinar, select this link and register: **ICR Webinar**.

PAPER FORMS

Providers can also request prior authorization by completing, printing and faxing the appropriate *Request for Preservice Review* forms found under the *Prior Authorization and Preservice Review* heading on the *Provider Resources* page of our website below:

https://mediproviders.anthem.com/ca/Pages/request-prior-authorization.aspx

Tips for filling out the forms and getting the fastest response to your authorization request:

- Fill out the form completely; unanswered questions typically result in delays.
- Print and fax the form to the numbers above.
- Do not store the form offline; access it online only. Anthem Blue Cross revises forms periodically, and outdated forms can delay your request.

Note: We do not reward practitioners and other individuals conducting utilization reviews for issuing denials of coverage or care. There are **no financial incentives** for UM decision-makers that encourage decisions resulting in underutilization. UM decision making is based only on appropriateness of care and service and existence of coverage.

SERVICES THAT DO NOT REQUIRE PRIOR AUTHORIZATION

The following services **do not** require prior authorization (PA) for in-network providers:

- Emergency services

- Post-stabilization services (if medically necessary)
- **Formulary** enteral nutrition products when provided by an in-network provider.
- Formulary glucometers and nebulizers
- Family planning/well woman checkup — members may self-refer to any Medicaid provider for the following services:
  - Pelvic and breast examinations
  - Lab work
  - Birth control
  - Genetic counseling
  - FDA-approved devices and supplies related to family planning (such as IUD)
  - HIV/STD screening
- Obstetrical care — no authorization required for in-network physician visits and routine testing
- Members not affiliated with an IPA or medical group do not require PA from Anthem Blue Cross for physician referrals to an in-network specialist for consultation or a nonsurgical course of treatment
- Standard X-rays and ultrasounds
- In-network speech therapy and occupational therapy

SERVICES THAT REQUIRE PRIOR AUTHORIZATION

Prior authorization ensures that services are based on medical necessity, are a covered benefit, and are provided by the appropriate providers.

Providers are responsible for verifying eligibility and ensuring that our Utilization Management (UM) department has conducted preservice reviews for elective nonemergency and scheduled services before rendering those services.

Prior authorization must be obtained for all out-of-network services or services rendered outside of an emergency room or urgent care setting.

Some Anthem Blue Cross members are assigned to delegated medical groups or IPAs. Providers should contact the member's assigned medical group to confirm the need for authorization before elective services.

Services requiring prior authorization include but are not limited to:

- Air ambulance (nonemergent)
- Behavioral health services (except psychiatric assessments and mental health assessment by non-physician; for more information, see **Chapter 5: Behavioral Health Services**)
- Cardiac and pulmonary rehabilitation
- Cosmetic procedures
- Dental (medically necessary facility and anesthesia services)
- Dialysis services
- Durable medical equipment and disposable supplies
- Experimental and investigational services
- Genetic testing
- Home health care services
- Hospice
- Infusion therapies
- Chemotherapy
- Inpatient hospital services
  - Nonurgent inpatient admissions
  - Long-term acute care facility (LTAC)
  - Inpatient skilled nursing facility (SNF)
  - Rehabilitation facility admissions
  - Newborn stay beyond mother
- Laboratory tests (specific)
- Out-of-network referrals to specialists

- Outpatient surgical services (delivered in an ambulatory surgical center or outpatient hospital)
- Pharmacy and/or over-the-counter (OTC) products

☎ Certain preferred medications and all nonpreferred medications may require PA; please call **1-844-410-0746** or fax CA DMHC standard PA form to **1-844-474-3345**.

☎ Specialty injectable medications such as Synagis and Botox require PA through Anthem Blue Cross. Contact the UM department at **1-888-831-2246** for more information.

- Radiology services including MRA, MRI, PET and CT scans
- Spinal surgeries
  - Artificial disc placement
  - Artificial disc removal
  - Artificial disc replacement
  - Decompress spinal cord
  - Low back disc surgery
  - Lumbar spine fusion
  - Remove spinal lamina
  - Vertebral corpectomy
- Kidney and cornea transplant services (excluding other major transplants-not covered by Anthem Blue Cross)

☎ A more comprehensive list of services requiring prior authorization can be found under *Prior Authorization and Preservice Review* on the *Provider Resources* page of our website at **https://mediproviders.anthem.com/ca**.

AUTHORIZATION CRITERIA

Authorizations are based on the following:

- Benefit coverage
- Established criteria
- Community standards of care

The decision-making criteria used by the UM team is evidence-based and consensus-driven. We periodically review criteria and update when standards of practice or technology change. We involve practicing physicians in these updates and notify providers of changes through our provider bulletins.

These criteria are available to members, physicians and other health care providers upon request by contacting the appropriate UM department using the contact numbers at the beginning of this chapter.

Based on sound clinical evidence, the UM team provides the following service reviews:

- Prior authorizations
- Continued stay reviews
- Post-service clinical claims reviews

Decisions affecting the coverage or payment for services are made in a fair, impartial, consistent and timely manner. The decision-making process incorporates nationally recognized standards of care and practice from sources including:

- America Academy of Orthopedic Surgeons
- American Academy of Pediatrics
- American College of Cardiology
- American College of Obstetricians and Gynecologists
- Cumulative professional expertise and experience

Once a case is reviewed, decisions and notification time frames will be given for these services:

- Approval, modification, denial

If you disagree with a UM decision and want to discuss the decision with the physician reviewer, please call:

☎ Peer-to-peer: **1-877-496-0071**

REQUESTING AUTHORIZATION

When authorization of a health care service is required, contact Anthem Blue Cross for questions or requests including:

- Routine, nonurgent care reviews
- Urgent or expedited preservice reviews
- Urgent continued stay reviews

Providers can also fax the UM team and include requests for:

☎ Preservice reviews: **1-800-754-4708**

☎ Nonurgent continued stay reviews: **1-866-333-4826**

Note: Faxes are accepted during and after normal business hours. Faxes received after business hours will be processed the next business day.

All providers including physicians, hospitals and ancillary providers are required to provide information to support their request to the UM department. Physicians are also encouraged to review their utilization and referral patterns.

When contacting the Utilization Management department to request a preservice review or report a medical admission, please provide the following information:

- Member name and identification (ID) number
- Diagnosis with the ICD-10 code
- Procedure with the CPT code
- Date of injury or hospital admission and third party liability information (if applicable)
- Facility name (if applicable)
- Primary care provider (PCP) name
- Specialist or attending physician name
- Clinical justification for the request
- Level of care
- Lab tests, radiology and pathology results
- Medications
- Treatment plan including time frames
- Prognosis
- Psychosocial status
- Exceptional or special needs issues
- Ability to perform activities of daily living
- Discharge plans

Additional information to have ready for the clinical reviewer includes but is not limited to:

- Office and hospital records
- History of the presenting problem
- Clinical exam
- Treatment plans and progress notes
- Information on consultations with the treating practitioner
- Evaluations from other health care practitioners and providers
- Photographs
- Operative and pathological reports
- Rehabilitative evaluations
- Printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics and information
- Information from responsible family members

REQUESTS WITH INSUFFICIENT CLINICAL INFORMATION

When the UM team receives requests with insufficient clinical information, we will contact the provider with a request for the information reasonably needed to determine medical necessity.

We will make at least one attempt to contact the requesting provider to obtain additional information. If no response if received within the specified time frame of receipt of the request, we will send a

Notice of Action: Denial —— Requested Information Not Received letter to the member and provider.

PRESERVICE REVIEW TIME FRAME

For routine, nonurgent requests, the UM team will complete preservice reviews within five business days from receipt of information reasonably necessary to make a decision, not to exceed 14 calendar days from the date of request.

Requests that do not meet medical policy criteria are sent to the physician advisor or medical director for further review.

Providers will be notified of denials or deferrals by phone or fax within one business day from the date of the decision.

Providers and members will be sent a written notification of denials or deferrals within two business days from the date of the decision.

URGENT PRESERVICE REQUESTS

For urgent preservice requests, the UM team will complete the preservice review within three calendar days from receipt of the request.

Providers are responsible for contacting Anthem Blue Cross to request preservice reviews for both professional and institutional services. However, a hospital or ancillary provider should always contact Anthem Blue Cross to verify preservice review status for all nonurgent care before rendering services.

An urgent request is any request for medical care or treatment that cannot be delayed because delay would result in one of the following:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function based on a prudent layperson's judgment.
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

EMERGENCY MEDICAL CONDITIONS AND SERVICES

Anthem Blue Cross does **not** require a prior authorization (PA) for treatment of emergency medical conditions. In the event of an emergency, members can access emergency services 24 hours a day, 7 days a week.

In the event that the emergency room visit results in the member's admission to the hospital, providers must contact Anthem Blue Cross within 24 hours or one business day if the member was admitted on a weekend or holiday.

Members who call their PCP's office reporting a medical emergency (whether during or after office hours) are directed to dial 911 or go directly to the nearest hospital emergency department. All nonemergent conditions should be triaged by the PCP or treating physician with appropriate care instructions given to the member.

EMERGENCY STABILIZATION AND POST-STABILIZATION

The emergency department's treating physician determines the services needed to stabilize the member's emergency medical condition. After the member is stabilized, the emergency department's physician must contact the member's PCP or Anthem Blue Cross for authorization of further services.

The member's PCP and the phone number to report inpatient admissions is noted on the back of the ID card. If the authorizing entity you contacted does not respond within 30 minutes, the needed services will be authorized. The attempt must be documented in the member's medical records and provided to Anthem Blue Cross UM in order to be considered authorized.

All continued inpatient stays are reviewed to determine whether the stay is medically necessary. The transfer process for out-of-network admissions requiring transfer to an Anthem
Blue Cross-contracted facility or to a higher level of care includes the following:

- The attending physician determines whether the member is stable for transfer

- The attending physician discusses the potential transfer with the PCP
- To facilitate the transfer, the PCP is required to contact the treating physician within 30 minutes of the call
- The attending physician must document and sign orders stating that the member is stable for transfer
- Transfers of children require the signed permission of the parents except in cases of transfer to a higher level of care

The emergency department should send a copy of the emergency room record to the PCP's office within 24 hours. The PCP should:

- Review the chart and file it in the member's permanent medical record
- Contact the member
- Schedule a follow-up office visit or a specialist referral if appropriate

However, as with all nonelective admissions, notification must be made within 24 hours or one business day if the member was admitted on a weekend or holiday. The medical necessity of that admission will be reviewed upon receipt of notification, and a determination of the medical necessity will be rendered within 72 hours of that notification.

All providers who are involved in the treatment of a member share responsibility in communicating clinical findings, treatment plans, prognosis and the psychosocial condition of such member with the member's PCP to ensure effective coordination of care.

CONTINUED STAY REVIEW

HOSPITAL INPATIENT ADMISSIONS

Hospitals must notify the UM department of inpatient medical admissions within 24 hours of admission or by the next business day. Behavioral health admissions are the responsibility of the member's county.

When a member's hospital stay is expected to exceed the number of days authorized during preservice review or when the inpatient stay did not have preservice review, the hospital must contact Anthem Blue Cross for continued stay review.

Anthem Blue Cross requires clinical reviews on all members admitted as inpatients to:

- Acute care hospitals
- Intermediate care facilities
- Skilled nursing facilities

We perform reviews to assess medical necessity and determine whether the facility and level of care are appropriate. Anthem Blue Cross identifies members admitted as inpatient by:

- Facilities reporting admissions
- Providers reporting admissions
- Members or their representatives reporting admissions
- Claims submitted for services rendered without authorization
- Preservice authorization requests for inpatient care

The Anthem Blue Cross UM team will complete continued-stay inpatient reviews within 72 hours of the receipt of necessary clinical information to make a determination consistent with the member's medical condition. Anthem Blue Cross UM staff will request clinical information from the hospital on the same day Anthem Blue Cross is notified of the member's admission and/or continued stay.

CLINICAL INFORMATION FOR CONTINUED-STAY REVIEW

If after notification of an inpatient admission, there is insufficient clinical information to determine medical necessity, the provider is contacted with a request for the clinical information reasonably necessary to determine medical necessity. Evidence-based criteria are used to determine medical necessity and the appropriate level of care.

If the information meets medical necessity review criteria, we will approve the request within 72 hours

from the time the information is received. Requests that appear to not meet medical policy guidelines will be sent to the physician adviser or medical director for further review.

Anthem Blue Cross will notify providers within 24 hours of the decision and send written notification of any denial or modification of the request to the member and requesting provider.

DENIAL OF SERVICE

Only a medical or behavioral health provider who possesses an active professional license or certification can deny services for lack of medical necessity including the denial of:

- Procedures
- Hospitalization
- Equipment

When a request is determined to be not medically necessary, the requesting provider will be notified of the following:

- The decision
- The process for appeal
- How to reach the reviewing physician for peer-to-peer discussion of the case

Providers can contact the physician clinical reviewers to discuss any UM decision by calling the UM department.

POST-SERVICE CLINICAL CLAIMS REVIEW

Post-service clinical claims review determines the medical necessity and/or level of care for services that were provided without getting required preservice or continued stay authorization. For inpatient admissions where no notification was received and no patient days were authorized, facilities are required to submit a copy of the medical record with the claim.

REFERRALS AND SECOND OPINIONS

REFERRALS TO SPECIALISTS

The UM team is available to assist providers in accessing a network specialist. Review the following when referring members:

- PA is **not** required if referring a member not affiliated with an IPA or medical group to an in-network specialist for consultation or a nonsurgical course of treatment.
- PA **is** required when referring to an out-of-network specialist.
- Authorization from UM is **not** required for Medi-Cal members who self-refer for sensitive services (see **Chapter 4: General Benefits**), even if services are rendered out-of-network.
- Members with MRMIP may self-refer to in-network specialists.

Provider responsibilities include documenting referrals in the member's chart and requesting that the specialist provide updates as to diagnosis and treatment.

Note: Obtain a PA approval before referring members to an out-of-network provider. For out-of-network providers, Anthem Blue Cross requires PA for the initial consultation and each subsequent service provided.

PCP REFERRALS

PCPs coordinate and make referrals to specialists, ancillary providers and community services. Providers should refer members to network facilities and providers. When this is not possible, providers should follow the appropriate process for requesting out-of-network referrals.

Note: Specialty referrals to in-network providers do not require PA from Anthem Blue Cross; however, please check with the member's medical group to confirm.

All PCPs are expected or responsible to:

- Help members schedule appointments with other providers and health education programs.
- Track and document appointments, clinical findings, treatment plans and care received by members referred to specialists or other health care providers to ensure continuity of care.
- Screen and evaluate procedures for detection and treatment of or referral for any known or suspected behavioral health problems and disorders.
- Refer members to specialists or specialty care, behavioral health services, health education classes and community resource agencies, when appropriate.
- Coordinate with the Woman, Infants and Children (WIC) program to provide medical information necessary for WIC eligibility determinations such as height, weight, hematocrit or hemoglobin.
- Coordinate with the local tuberculosis (TB) control program to ensure that all members with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy (DOT).
- Refer members to specialists or specialty care, behavioral health services, health education classes and community resource agencies including the California Department of Developmental Services regional centers, which are responsible for the Early Start Program (ESP) for children up to 3 years of age with developmental disabilities. Community resources also include the Child Health and Disability Prevention Program (CHDP), and California Children's Services (CCS).

Note: Whenever a provider refers a member to any of these community-based agencies, complete and fax the **Notification of Referral/Linked and Carved-Out Services** form to Utilization Management at:

☎ Utilization Management: **1-888-334-0870**

☎ Utilization Management fax: **1-866-333-4827**

The *Notification of Referral/Linked and Carved-Out Services* form can be found by selecting the URLs below:

Forms Library

Provider Resources: **https://mediproviders.anthem.com/ca**

OUT-OF-NETWORK REFERRALS

Anthem Blue Cross recognizes that there may be instances when an out-of-network referral is justified. Medi-Cal's Utilization Management team will work with the PCP to determine medical necessity; after that, out-of-network referrals will be authorized on a limited basis. The UM department may be contacted at:

☎ Medi-Cal Utilization Management: **1-888-831-2246**

☎ Medi-Cal Utilization Management fax: **1-866-333-4827**

☎ Hours of operation: Monday to Friday, 8 a.m. - 5 p.m.

SELF-REFERABLE SERVICES

Members may self-refer to any of the following services without PA if their benefits allow.

- Emergency services
- Abortion services (in-network only)
- Annual well-woman exam (in-network only)
- Diagnosis and treatment of sexually transmitted diseases (STD)
- Family planning services (services to prevent or delay pregnancy)
- Basic prenatal services (in-network only)
- Testing and counseling for Human Immunodeficiency Virus (HIV)

Members associated with capitated medical groups must self-refer to services within the group.

Note: Self-referable services may be rendered by a willing provider, even a provider without a contract, unless limited by state of federal regulation. We reimburse contracted providers according to the provider's contract; noncontracted providers are reimbursed at reasonable and customary rates.

SECOND OPINIONS

Second opinions are covered services and offered at no cost to Anthem Blue Cross members. The following are important guidelines regarding second opinions:

- The second opinion must be given by an appropriately qualified health care professional.
- The second opinion must come from a provider of the same specialty.
- The secondary specialist must be within the Anthem Blue Cross network and may be selected by the member. When there is no network provider who meets the specified qualifications, Anthem Blue Cross may authorize a second opinion by a qualified provider outside of the network upon request by the member or provider.

TRANSITION AND DISCHARGE PLANNING

☎ Anthem Blue Cross assists with discharge planning as requested by the facility. For assistance with discharge planning, please call **1-805-713-0845**.

CARE MANAGEMENT

☎ Care Management department: **1-888-334-0870**

☎ Care Management fax: **1-866-333-4827**

☎ Hours of operation: Monday to Friday, 8 a.m. - 5 p.m.

Anthem Blue Cross care management is a process that emphasizes teamwork to assess, develop, implement, and coordinate treatment plans in order to optimize our members' health care benefits and promote quality outcomes.

Members referred to the Care Management team may be identified by disease, condition or high utilization of services.

REFERRAL PROCESS

Anyone may refer members to Care Management by phone or faxing a *Care Management Referral Form* to the Care Management office using the numbers at beginning of this chapter.

The Medi-Cal ***Care Management Referral Form*** is located in the General Forms Library on the *Provider Resources* page of our website at:

https://mediproviders.anthem.com/ca/pages/forms.aspx

A care manager will respond to a faxed request within three business days.

ROLE OF THE CARE MANAGER

The care manager, through discussions with the member, the member's representative and/or providers, collects data and analyzes information about actual and potential health care needs for the purpose of developing a treatment plan. The care manager's role also includes the responsibility to:

- Facilitate communication and coordination within the health care team, member or member representative.
- Educate the member and providers, on the health care team, about care management programs, community resources, benefits, and all related topics so that informed decisions can be made.
- Encourage appropriate use of medical facilities and services with the goal of improving quality of care.

The Care Management team includes experienced and credentialed registered nurses and Social Workers, some of whom are **certified case managers** (CCMs). The team also uses Community Health Workers to reach members in the community or in their home. The Care Management multidisciplinary team allows us to address not only our members' medical needs, but also their psychological, and social determinants of health.

To support our diverse membership, the Care Management team is able to provide culturally and linguistically appropriate community-based referrals as needed.

Interpreter services are also available to support the care management process at no cost to the member.

PROVIDER RESPONSIBILITY

Providers have the responsibility of participating in care management**,** sharing information and facilitating the process by:

- Referring members who could benefit from care management.
- Sharing information as soon as possible including any complex health care needs identified during the Initial Health Assessment (IHA).
- Collaborating with Care Management staff on an ongoing basis.
- Recommending referrals to specialists as required.
- Monitoring and updating the care plan to promote health care goals.
- Notifying Care Management if members are referred to services provided by the state or some other institution not covered by the Anthem Blue Cross agreement.

- Coordinating county or state-linked services such as public health, behavioral health, schools and waiver programs. The provider may call Care Management for additional assistance.

PROCEDURES

When a member has been identified as having a condition that may require care management, the care manager contacts the referring provider and member for an initial assessment.

With the involvement of the member, the member's representative and the provider, the care manager develops an individualized care plan. That plan may involve coordinating services with public and behavioral health departments, schools and other community health resources.

The care manager periodically reassesses the care plan to monitor the following:

- Progress toward goals
- Necessary revisions
- New issues that need to be addressed to help ensure that the member receives the support needed to achieve care plan goals

Once goals are met or Care Management can no longer impact the case, the care manager closes the member's case.

MEMBERS ELIGIBLE FOR SPECIALIZED SERVICES

The Care Management team works closely with providers to ensure continuity and coordination of care for our members who are eligible for linked and state-administered services. These services may come from the following:

- California Children's Services (CCS)
- County Mental Health Care
- Early Start/Early Intervention
- Regional Centers

Although these agencies provide specialized services for our members, PCPs remain responsible for providing or arranging for the provisions of all necessary and preventive medical services.

POTENTIAL REFERRALS

Providers, nurses, social workers, and members or their representatives may request care management services. Examples of appropriate referrals include:

- Children or adults with special health care needs requiring coordination of care and carved out services such as certain mental health services
- HIV/AIDS
- Chronic illnesses such as asthma, diabetes, heart failure or end-stage renal disease
- Complex or multiple care needs such as multiple trauma or cancer
- Frequent hospitalizations or emergency room utilization
- Hemophilia, sickle cell anemia, cystic fibrosis, cerebral palsy
- High-risk pregnancies (i.e., teen pregnancies, history of pre-term birth, etc.)
- Potential transplants
- Seniors and persons with disabilities (SPD)
- Individuals who may need or are receiving services from out-of-network providers or programs

TRANSITIONING DISENROLLEES

The care manager is available to assist a member that requests help to transition to another health plan. Providers may contact Care Management if assistance is needed.

PROVIDER ASSESSMENT OF PREGNANCY RISK

The PCP or prenatal care physician should assess all pregnant members for high-risk indicators during the initial prenatal care visit. For all pregnant members, the provider needs to:

- Complete a *Pregnancy Notification Report* and submit it to our prenatal program coordinator at:

  ☎ **1-877-848-0147**

- Refer members to prenatal education, childbirth education and breastfeeding classes; members can register by calling our Customer Care Centers.
- Document all referrals in the member's medical record.
- Schedule the member for a postpartum visit.

For additional information, visit the *Prenatal Resources* page of our website at:

https://mediproviders.anthem.com/ca/pages/prenatal-resources.aspx

CONTINUITY OF CARE

Anthem Blue Cross provides continuity of care for members with qualifying conditions when health care services are not available within the network or when the member or provider is in a state of transition.

All new enrollees receive a Member Services Guide/Evidence of Coverage (**EOC**) and membership information in their enrollment packets. This provides information regarding members' rights to request continuity of care if the member transitions to another health plan.

Qualifying condition: A medical condition that may qualify a member for continued access to care and continuity of care. These conditions include but are not limited to:

- Acute conditions (i.e., cancer)
- Degenerative and disabling conditions, which includes conditions or diseases caused by a congenital or acquired injury or illness that require a specialized rehabilitation program or a high level of service, resources or coordination of care in the community
- Newborns who are covered between the ages of birth and 36 months
- Pregnancy, regardless of trimester, through immediate postpartum care
- Surgery that has been previously approved and scheduled to occur within 180 days of the contract's termination or within 180 days of the effective date of coverage for a newly covered enrollee
- Serious chronic conditions (i.e., hemophilia)
- Terminal illness

States of transition may be any of the following:

- The member is newly enrolled.
- The member is disenrolling to another health plan.
- The provider's contract terminates.

A terminated provider or provider group who actively treats members must continue to treat members until the provider's date of termination. Anthem Blue Cross makes every effort to notify members at least 30 days prior to termination.

Providers help ensure continuity and coordination of care through collaboration. This includes the confidential exchange of information between PCPs and specialists as well as behavioral health providers. In addition, Anthem Blue Cross helps coordinate care when a provider's contract has been discontinued to ensure a smooth transition to a new provider.

Providers must maintain accurate and timely documentation in the member's medical record including but not limited to:

- Consultations
- Prior authorizations
- Referrals to specialists
- Treatment plans

All providers share responsibility in communicating clinical findings, treatment plans, prognosis and the member's psychosocial condition as part of the coordination process. Utilization management nurses review member and provider requests for continuity of care. These nurses facilitate continuation with the current provider until a

short-term regimen of care is completed or the member transitions to a new practitioner.

Note: Only Anthem Blue Cross can make adverse determination decisions regarding continuity of care.

Adverse determination decisions are sent in writing to the member and provider within two business days of the decision. Members and providers can appeal the decision by following the procedures in the **Grievances and Appeals** chapter of this manual. Reasons for continuity of care denials include but are not limited to the following:

- Continuity of care is not available with the terminating provider.
- Course of treatment is complete.
- Member is ineligible for coverage.
- Condition is not a qualifying condition.
- Request is for change of PCP only and not for continued access to care.
- Requested services are not a covered benefit.
- Services rendered are covered under a global fee.
- Treating provider is currently contracted with our network.

DISEASE MANAGEMENT PROGRAMS

☎ Providers can refer a member to the program by calling DM at **1-888-830-4300**.

☎ Hours of operation are 8:30 a.m. - 5:30 p.m. local time. Confidential voicemail is available 24 hours a day.

DM program content is located at: **https://mediproviders.anthem.com/ca/pages/dmccu.aspx**

Referral Form: **https://mediproviders.anthem.com/Documents/CACA_CAID_DiseaseMgmtReferralForm.pdf**

DISEASE MANAGEMENT

Disease Management (DM) services are based on a system of coordinated care management interventions and communications designed to help physicians and other health care professionals manage members with chronic conditions.

Our services include a holistic, member-centric care management approach that allows care managers to focus on multiple needs of members.

Our disease management programs include:

- Asthma
- Bipolar disorder
- Chronic obstructive pulmonary disorder (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Diabetes
- HIV/AIDS
- Hypertension
- Major depressive disorder – adult and child/adolescent
- Schizophrenia
- Substance abuse disorder

In addition to our 12 condition-specific disease management programs, our member-centric, holistic approach also allows us to assist members with managing their weight and/or smoking cessation education.

Program features:

- Proactive identification process
- Evidence-based *Clinical Practice Guidelines* from recognized sources
- Collaborative practice models that include the physician and support providers in treatment planning
- Continuous self-management education
- Ongoing process and outcomes measurement, evaluation and management

- Ongoing communication with primary and ancillary providers regarding patient status

WHO IS ELIGIBLE?

All members with the listed conditions are eligible. We identify them through:

- Continuous case finding
- Claims mining
- Referrals

As a valued provider, we welcome your referrals of patients who can benefit from additional education and disease management support. Our care managers will work collaboratively with you to obtain your input in the development of care plans. Members identified for participation in any of the programs are assessed and risk stratified based on the number of gaps in care/needs.

Members enrolled in Disease Management programs receive education on self-management concepts, which include primary prevention, coaching related by healthy behaviors and compliance/ monitoring as well as case/care management for high-risk members. Providers are given telephonic and/or written updates regarding patient status and progress.

DM Provider Rights and Responsibilities

You have the right to:

  - Obtain information about our organization's services, staff qualifications and any contractual relations.
- Decline to participate in or work with the organzation's programs and services on behalf of their patients
- Be informed of how the organization coordinates interventions with care plans for individual members
- Know how to contact the case manager responsible for managing and communicating with their patients
- Be supported by our organization when interacting with members to make decisions about their health care
- Receive courteous and respectful treatment from our organization's staff
- Communicate complaints to the organization.

HOURS OF OPERATION

Our DM case managers are registered nurses. They are available: 8:30 a.m. to 5:30 p.m. local time.

Confidential voicemail is available 24 hours a day. The NurseLine is available for our members 24 hours a day, 7 days a week.

Contact Information

☎ You can call a DM team member at **1-888-830-4300**.

DM program content is located at **https://mediproviders.anthem.com/ca**.

Printed copies are available upon request.

Members can obtain information about DM program by visiting: **www.anthem.com/ca/medi-cal**

☎ or calling **1-888-8630-4300**.

HEALTH SERVICE PROGRAMS

MATERNAL CHILD SERVICES: NEW BABY, NEW LIFE

☎ If you have an Anthem Blue Cross member in your care that would benefit from the New Baby, New Life program, please call us at **1-888-334-0870**.

New Baby, New Life℠ is a proactive care management program for all expectant mothers and their newborns. It identifies pregnant women as early in their pregnancies as possible through review of state enrollment files, claims data, lab reports, hospital census reports, and provider notification of pregnancy and delivery notification forms and self-referrals.

Once pregnant members are identified, we act quickly to assess obstetrical risk and ensure appropriate levels of care and case management services to mitigate risk. Experienced case managers work with members and providers to establish a care plan for our highest risk pregnant members. Case managers collaborate with community agencies to ensure mothers have access to necessary services including transportation, WIC, home-visitor programs, breastfeeding support and counseling.

When it comes to our pregnant members, we are committed to keeping both mom and baby healthy. That's why we encourage all of our moms-to-be to take part in our New Baby, New Life program — a comprehensive case management and care coordination program offering:

- Individualized, one-on-one case management support for women at the highest risk.
- Care coordination for moms who may need a little extra support.
- Educational materials and information on community resources.
- Incentives to keep up with prenatal and postpartum checkups and well-child visits after the baby is born.
- For parents with infants admitted to the neonatal intensive care unit (NICU), we offer the *You and Your Baby in the NICU* program. Parents receive education and support to be involved in the care of their babies, visit the NICU, interact with hospital care providers and prepare for discharge. Parents are provided with an educational resource outlining successful strategies they may deploy to collaborate with the care team.

Beginning July 1, 2019, obstetric providers are required to screen or offer to screen women for perinatal mood disorders.

The American College of Obstetricians and Gynecologists has outlined depression screening instruments to be used during the pregnancy and postpartum periods including:

- The Edinburgh Postnatal Depression Scale (EPDS).
- Patient Health Questionnaire 9.

Providers are asked to document screening in the medical record.

☎ For referrals to care coordination for behavioral health, please call **1-888-831-2246** and select **1** then option **2** to request care coordination.

Maternal Outreach Program

The Maternal Outreach Program is designed to identify mothers with prenatal and postpartum support needs. Anthem Blue Cross will contact pregnant women and new mothers by telephone to identify any prenatal or postpartum needs, answer questions and share information about member resources. Anthem Blue Cross will also educate new mothers about well-child visits and immunizations.

We will also assist with appointment scheduling to encourage women to get their check-ups.

The program will allow Anthem Blue Cross and its providers to:

- Establish eligibility for care management programs.
- Ensure mothers and babies receive appropriate medical care.
- Increase prenatal, postpartum and well-child follow-up visits.
- Enhance member engagement.
- Increase quality health care outcomes for mothers and their babies.
- Raise HEDIS® scores.

CLINICAL PRACTICE GUIDELINES

Several national organizations produce guidelines for asthma, diabetes, hypertension and other conditions. The guidelines, which Anthem Blue Cross uses for quality and disease management programs, are based on reasonable

medical evidence. We review the guidelines at least every two years or when changes are made to national guidelines for content accuracy, current primary sources, new technological advances and recent medical research.

Clinical Practice Guidelines can be downloaded at:

- **https://mediproviders.anthem.com/ca/pages/quality-improvement-program.aspx**
- **Behavioral health: https://mediproviders.anthem.com/ca/pages/clinical-practice-guidelines.aspx**
- **Matrix: https://mediproviders.anthem.com/Documents/CACA_CAID_ClinicalPracticeGuidelinesMatrix.pdf**

☎ You can also call Provider Services at **1-866-231-0847** to receive a copy.

13 | QUALITY MANAGEMENT

The Anthem Blue Cross longstanding goal has been continuous, measurable improvement in our delivery of quality health care. Following federal and state guidelines, we have a Quality Management (QM) program to:

- Objectively and systematically monitor and evaluate the quality, safety and appropriateness of medical care and service offered by the health network.
- Identify and act upon opportunities for improvement.

The QM program includes focused studies and reviews that measure quality of care in specific clinical and service areas. All providers are expected to participate in these studies as part of our mutual goal of providing responsive and cost-effective health care that improves our member's lives.

QUALITY PERFORMANCE REQUIREMENTS

Anthem Blue Cross participates in national and state evaluations that measure the quality performance of our plan and providers. The **National Committee for Quality Assurance** (NCQA) provides a national annual report of their **Healthcare Effectiveness Data and Information Set** (HEDIS) rankings across health plans.

This report is a tool used by more than 90% of America's health plans to rate performance across a wide spectrum of care and service areas including clinical performance and member satisfaction. The HEDIS results can also be used by anyone to make comparisons before choosing a health plan. Anthem Blue Cross uses the HEDIS data to identify areas for improvement and shares the results with providers.

The **California Department of Healthcare Services** (DHCS) has selected a set of quality measures that apply to all Medi-Cal Managed Care Plans (MCPs). These quality measures are known as the **Managed Care Accountability Set** (MCAS), formerly known as the External Accountability Set (EAS). MCPs are ***required*** to perform at the least as well as 50% of all Medicaid plans in the United States (50th percentile).

This requirement is known as the **Minimum Performance Level** (MPL) and it applies to all measures that are a part of the MCAS. When the MPL is not met for any measure within the MCAS, DHCS may impose the following actions on the MCP:

- Corrective Action Plans
- Sanctions
- PDSA/PIP Participation

All applicable Anthem Blue Cross network providers, including safety net clinics, independent practitioners, Physician Medical Groups (PMGs), Independent Physician Associations (IPAs), Public Hospitals and other health systems are **required** to meet the MPL for **all** measures within the DHCS selected MCAS. Anthem Blue Cross reserves the right to and may impose sanctions on any provider that does not meet the MPL, including, but not limited to:

- Sending a quality performance notices that requires completion of specific QI interventions
- Suspending auto-assignment of members that didn't choose a provider
- Freezing panels for assignment of any new members
- Withholding 5-15% of capitation payments at Anthem discretion
- Terminating contracts for material breach or according to other termination provisions

REPORTING MEASURES FOR 2019 2019 Managed Care Accountability Set (MCAS) measures that must meet DHCS Minimum Performance Levels (MPL)			
ACRYNOM	**NAME**	**DESCRIPTION**	**HYBRID**
ABA	**Adult BMI Assessment**	Members 18-74 who had an outpatient visit and whose body mass index was documented during the measurement year, or the year prior. **Please note**: 1) for ages 18-19 medical record must document the weight, height, and BMI percentile 2) for ages 20-74 medical record must document the weight and BMI value	Y
ADD - Behavioral Health (Initiation Phase)	**Follow-Up Care for Children Prescribed ADHD Medications**	Children ages 6-12 newly prescribed ADHD medication and who had at least 3 follow-up care within a 10 month period. The 1st visit has to be within 30 days following the Index Prescription Start Date (IPSD) and must be with a practitioner with prescribing authority	N
ADD - Behavioral Health (Continuation and Maintenance)	**Follow-Up Care for Children Prescribed ADHD Medications**	Children ages 6-12 newly prescribed ADHD medication and who had at least 3 follow-up care within a 10 months period. Continuation Phase is for members who remained on the medication 210 days and who, in addition to the initial visit, had at least 2 follow-up visits within 9 months	N
AMM - Behavioral Health (Acute)	**Antidepressant Medication Management**	Members 18 years or older, who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication for at least 84 days (12 weeks)	N
AMM - Behavioral Health (Continuation)	**Antidepressant Medication Management**	Members 18 years or older, who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication for at least 180 days (6 months)	N
AMR	**Asthma Medication Ratio**	Members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year	N
AWC	**Adolescent Well Care**	Members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year	Y
BCS	**Breast Cancer Screening**	Women 50–74 years of age who had a mammogram to screen for breast cancer	N
CBP	**Controlling Blood Pressure**	Members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year	Y
CCS	**Cervical Cancer Screening**	Women 21–64 years of age who had cervical cytology performed every 3 years, or women 30–64 years of age who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years	Y
CDC-A1C	**Comprehensive Diabetic Care-A1c Test**	Percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had Hemoglobin A1c (HbA1c) testing	Y
CDC-A1C>9	**Comprehensive Diabetes Care-Poor Control >9**	Percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c poor control (>9.0%)	Y
CHL	**Chlamydia Screening**	Women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year	N

REPORTING MEASURES FOR 2019			
2019 Managed Care Accountability Set (MCAS) measures that must meet DHCS Minimum Performance Levels (MPL)			
CIS – COMBO 10	**Childhood Immunizations Status- Combo 10**	Children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday	Y
IMA – COMBO 2	**Immunizations For Adolescents- Combo 2**	Adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday	Y
PPC-POST	**Timeliness for-Postpartum Care**	The percentage of women who had a postpartum visit on or between 21 and 56 days after delivery.	Y
PPC-PRE	**Timeliness for-Prenatal Care**	The percentage of pregnant women who received a prenatal care visit in the first trimester or within 42 days of enrollment	Y
W15	**Well Child Visits- 0-15 months**	The percentage of members who turned 15 months old during the measurement year and who had 6+ well-child visits with a PCP during their first 15 months of life	Y
W34	**Well Child Visits-3-6 years**	The percentage of members 3–6 years of age who had one or more well-child visits with a PCP during the measurement year	Y
WCC - BMI	**Weight Assessment & Counseling for Nutrition and Physical Activity**	Members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation (height, weight, BMI percentile)	Y

QUALITY MANAGEMENT PROGRAM DOCUMENTATION

The QM program focuses on developing and implementing standards for clinical care and service, measuring conformity to those standards, and taking action to improve performance. The scope of the QM program includes but is not limited to the monitoring and evaluation of:

- Care and service provided in all health delivery settings
- Chronic disease management and prevention programs
- Maternity management programs
- Coordination of medical care
- Community health
- Service quality
- Case management of members with complex health conditions
- Facility site review
- Medical record review
- HEDIS medical record review
- Provider/member satisfaction
- Member/patient safety
- Utilization management
- Behavioral health programs
- Pharmacy and therapeutics
- Clinical practice guidelines
- Over and under utilization

Anthem Blue Cross develops an annual work plan of quality improvement activities based on the results of the previous year's QM program evaluation. QM program revisions are made based on outcomes, trends, accreditation, contractual and regulatory standards and requirements, and overall satisfaction with the effectiveness of the program.

The QM program evaluation is the reporting method used to evaluate the progress of each provider's quality performance and results of planned activities toward established goals.

Providers support the activities of the QM program by:

- Participating in the facility and medical record audit process and completing corrective action plans (CAPs) when applicable.
- Providing access to medical records for quality improvement projects and studies and HEDIS review
- Responding in a timely manner to requests for written information and documentation if a quality of care or grievance issue has been filed
- Using Preventive Health and Clinical Practice Guidelines in member care
- Sharing imperative data files, such as EMR and lab files
- Using the immunization registry
- Participating in performance improvement activities

Information from these studies is actively shared with providers and we encourage constructive feedback.

COMMUNITY ADVISORY COMMITTEE

Community Advisory Committees (CAC) provide input and recommendations to the Board of Directors, Medical Advisory Committee and Quality department on programs and issues. These advisory functions include providing input on topics such as priorities for needs assessment, program development and provider network development.

The CAC meets periodically in our California counties with representatives from Quality Management, Provider Relations, Community-Based Organizations and Anthem Blue Cross members enrolled in Medi-Cal in attendance.

The responsibilities of the CAC are to:

- Give input to Anthem Blue Cross on the needs of the community.

- Provide suggestions on possible approaches and strategies to address issues raised by our members.
- Review and comment on group needs assessment results.
- Identify community resources to enhance the services offered to Anthem Blue Cross members.
- Be included and involved in policy decisions related to quality improvement, educational, operational and cultural competency issues affecting groups who speak a primary language other than English.

PROVIDER PERFORMANCE DATA

Practitioners and providers must allow Medi-Cal and MRMIP to use performance data in cooperation with our quality improvement program and activities.

Provider performance data refers to compliance rates, reports and other information related to the appropriateness, cost, efficiency and/or quality of care delivered by an individual health care practitioner such as a physician or a health care organization such as a hospital. Common examples of performance data would include the HEDIS quality of care measures maintained by the NCQA and the comprehensive set of measures maintained by the National Quality Forum (NQF).

Practitioner/provider performance data may be used for multiple plan programs and initiatives including but not limited to:

- **Reward programs:** Pay for performance (P4P), pay for value (PFV) and other results-based reimbursement programs that tie provider or facility reimbursement to performance against a defined set of compliance metrics. Reimbursement models include but are not limited to shared savings programs, enhanced fee schedules and bundled payment arrangements.
- **Recognition programs:** Programs designed to transparently identify high-value providers and facilities and make that information available to consumers, employers, peer practitioners and other health care stakeholders.

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS)

HEDIS is a national evaluation and core set of performance measurements that gauge the effectiveness of Anthem Blue Cross and its providers in providing quality care. Anthem Blue Cross will provide the necessary education and training you and your office staff need to participate in required HEDIS evaluations. Providers can request consultations and training in the following areas:

- Information about the year's selected HEDIS studies
- How data for those measures will be collected
- Codes associated with each measure
- Tips for smooth coordination of medical record data collection

Our QM staff will contact your office when we need to review or copy any medical records required for HEDIS or QM studies. Requests to provider offices begin in early February. Anthem Blue Cross requests the records be returned within five business days to allow time to abstract the records and request additional information from other providers if needed. Office staff must provide access to medical records for review and copying free of charge.

OVER/UNDER UTILIZATION

In accordance with NCQA standards, Anthem Blue Cross analyzes relevant utilization data against established thresholds for each health plan to detect potential over or under utilization.

If our findings fall outside specified target ranges and indicate potential underutilization or overutilization that may adversely affect our members, further analyses will occur based upon

the recommendation of The Anthem Blue Cross **Utilization Management Committee** (UMC).

The follow-up analyses may include gathering the following data from specific provider and practice sites:

- Care management services needed by members
- Claims payments for covered services
- Coordination with other providers and agencies
- Focus studies
- Investigation and resolution of member and provider grievances and appeals within established time frames
- Retrospective reviews of services provided without authorization

GAPS IN CARE

The QM Department regularly tracks member utilization for nationally recognized standards of care. When members are due for care or gaps in care are identified, QM outreach staff engages with members directly. QM staff conducts outreach calls to the members, during which staff:

- Educate members on the importance of receiving their care.
- Identify barriers to care (e.g., transportation) and work with members to overcome those barriers.
- Assist members with the scheduling of appointments.

The main health care service delivery areas targeted during member outreach include:

- Prenatal and postpartum care
- Chronic disease management (for example, diabetes, asthma, hypertension)
- Childhood immunizations and well-child visits
- Routine preventive screenings (for example, breast cancer screening and pap smears)

Health topics may be targeted if significant gaps in care are identified by the QM team. QM staff is also available to support the network in closing gaps in care.

MEMBER SATISFACTION SURVEYS

Member satisfaction with our health care services is measured every year by the **Consumer Assessment of Healthcare Providers and Systems** (CAHPS®) survey. The survey is an NCQA requirement and is designed to measure member satisfaction with services provided by Anthem Blue Cross and our network providers including:

- Access to care
- Physician care and communication with patients
- Anthem Blue Cross Customer Service

Anthem Blue Cross shares results of the CAHPS survey with our network providers upon request. Providers can review the results, share them with office staff, and incorporate appropriate changes to their offices in an effort to improve scores.

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

PROVIDER SATISFACTION SURVEYS

Anthem Blue Cross conducts provider surveys to monitor and measure provider satisfaction with our services and identify areas for improvement. Provider participation in these surveys is highly encouraged, and your feedback is very important. We inform providers of the results and plans for improvement through provider bulletins, newsletters, meetings or training sessions.

MEDICAL RECORDS AND FACILITY SITE REVIEWS

As required by California statute, all PCP sites participating in the Medi-Cal program must undergo an initial site inspection and subsequent periodic

site inspections regardless of the status of other accreditation or certification.

Anthem Blue Cross conducts subsequent inspections every three years in order to determine:

- Provider compliance with standards for providing and documenting health care.
- Provider compliance with standards for documenting and storing medical records.
- Provider compliance with processes that maintain safety standards and practices.

Provider involvement in the continuity and coordination of member care. **Note:** DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), Department of Managed Health Care (DMHC), or their designees and Anthem Blue Cross have the right to enter into the premises of providers to inspect, monitor, audit or otherwise evaluate the work performed. We perform all inspections and evaluations in such a manner as not to unduly delay work in accordance with the provider contract.

Medical records and facility site review tools are available under the *Quality Improvement Program* heading on the *Provider Resources* page of our website at:

https://mediproviders.anthem.com/ca/pages/quality-improvement-program.aspx

FACILITY SITE REVIEW PROCESS

A **facility site review** (FSR) inspection is broken down into the following six categories:

- Access/safety
- Personnel
- Office management
- Clinical services
- Preventive services
- Infection control

The Anthem Blue Cross Quality Management team will call the provider's office to schedule an appointment date and time before the FSR due date. The team will fax, email or mail a confirmation letter with an explanation of the audit process and required documentation.

During the FSR, our auditor will:

- Conduct a review of the facility and medical records
- Develop a Corrective Action Plan if applicable.

After the FSR is completed, our auditor will meet with the provider or office manager to:

- Review and discuss the results of the facility site review and explain any required corrective actions.
- Provide a copy of the facility site review results and the CAP to the office manager or provider.
- Educate the provider and office staff about our standards and policies.
- Schedule a follow-up review for any corrective actions identified.

Providers must obtain a score of 80% or greater in both the facility site review and the medical record review in order to pass.

FACILITY SITE REVIEW: CORRECTIVE ACTIONS

If the facility site review or the medical record review results in a nonpassing or conditional score,

Anthem Blue Cross will immediately notify providers of the results as well as all cited deficiencies and corrective action requirements. The provider office will develop and submit a CAP as follows:

- Correct critical deficiencies **within 10 days** following the FSR
- Develop and submit a CAP for all other deficiencies **within 45 days**
- Sign an attestation when corrective actions are complete

If deficiencies (other than critical) are not closed within 45 days from the date of the written CAP request or the practitioner is otherwise uncooperative with resolving outstanding issues with the facility site review, the provider will be considered noncompliant.

Critical elements include:

- Exit doors and aisles are unobstructed and escape accessible
- Airway management equipment is available
- Emergency medicine is available
- Only qualified/trained personnel retrieve, prepare or administer medications.
- Physicians review and follow-up referral/consultation reports and diagnostic test results
- Only lawfully authorized persons dispense drugs to patients
- Drugs and Vaccines are prepared and drawn only prior to administration.
- Personal Protective Equipment for Standard Precautions is readily available for staff use.
- Needles stick safety precautions are practiced on site
- Blood, other potentially infectious materials and regulated wastes are cared for and disposed of appropriately
- Spore testing of autoclaves completed monthly.

Facilities must demonstrate 100% percent compliance with these elements.

Provider sites that score below 80% in the facility site review for two consecutive reviews must score a minimum of 80% in the next review.

Sites that don't score a minimum of 80% will be removed from the network, and the provider's members will be appropriately reassigned to other participating providers.

MEDICAL RECORDS STANDARDS

Anthem Blue Cross requires providers to maintain medical records in a manner that is current, organized and permits effective and confidential member care and quality review. Anthem Blue Cross performs medical record reviews of all PCPs and OB/GYNs (acting as PCPs) upon signing of a contract and, at a minimum, every three years thereafter to ensure that network providers are in compliance with these standards.

CONFIDENTIALITY

Network providers shall agree to maintain the confidentiality of member information and information contained in a member's medical records according to the **Health Information Privacy and Accountability Act** (HIPAA) standards. The Act prohibits a provider of health care from disclosing any individually identifiable information regarding a patient's medical history, mental and physical condition, or treatment without the patient's or legal representative's consent or specific legal authority and will only release such information as permitted by applicable federal, state and local laws and that is:

- Necessary to other providers and the health plan related to treatment, payment or health care operations
- Upon the member's signed and written consent

SECURITY

The medical record must be secure and inaccessible to unauthorized access in order to prevent loss, tampering, disclosure of information,

alteration or destruction of the record. Information must be accessible only to authorized personnel within the provider's office, Anthem Blue Cross, DHCS or to persons authorized through a legal instrument.

Office personnel will ensure that individual patient conditions or information is not discussed in front of other patients or visitors, displayed, or left unattended in reception and/or patient flow areas.

STORAGE AND MAINTENANCE

Active medical records shall be secured and must be inaccessible to unauthorized persons. Medical records are to be maintained in a manner that is current, detailed and organized, and that permits effective patient care and quality review while maintaining confidentiality. Inactive records are to remain accessible for a period of time that meets state and federal guidelines.

Electronic recordkeeping system procedures shall be in place to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures and maintain upkeep of computer systems.

Security systems shall be in place to provide back-up storage and file recovery, to provide a mechanism to copy documents, and to ensure that recorded input is unalterable.

AVAILABILITY OF MEDICAL RECORDS

The medical records system must allow for prompt retrieval of each record when the member comes in for a visit. Providers must maintain members' medical records in a detailed and comprehensive manner that accomplishes the following:

- Conforms to good professional medical practice
- Facilitates an accurate system for follow-up treatment
- Permits effective professional medical review and medical audit processes

Medical records must be legible, signed and dated.

Providers must offer a copy of a member's medical record upon reasonable request by the member at no charge, and the provider must facilitate the transfer of the member's medical record to another provider at the member's request.

Confidentiality of and access to medical records must be provided in accordance with the standards mandated in HIPAA and all other state and federal requirements.

Providers must permit Anthem Blue Cross and representatives of DHCS to review members' medical records for the purposes of:

- Monitoring the provider's compliance with medical record standards
- Capturing information for clinical studies or HEDIS
- Monitoring quality
- Any other reason

MEDICAL RECORD DOCUMENTATION STANDARDS

Every medical record is to include at a minimum:

- The patient's name or ID number on each page in the record
- Personal biographical data including date of birth, home address, emergency contact name and telephone number, home and work telephone numbers, and marital status
- All entries dated with month, day and year
- All entries with the author's identification (for example, handwritten signature, unique electronic identifier or initials) and title
- Identification of all providers participating in the member's care and information on services furnished by these providers
- A problem list including significant illnesses and medical and psychological conditions
- Presenting complaints, diagnoses and treatment plans including the services to be delivered
- Physical findings relevant to the visit including vital signs, normal and abnormal findings, and appropriate subjective and objective information

- Information on allergies and adverse reactions (or a notation that the patient has no known allergies or history of adverse reactions)
- Information on advance directives
- Past medical history including serious accidents, operations, illnesses, and for patients 14 years old and older, substance abuse (for children and adolescents, past medical history relates to prenatal care, birth, operation and childhood illnesses)
- Physical examinations, treatment necessary and possible risk factors for the member relevant to the particular treatment
- Prescribed medications including dosages and dates of initial or refill prescriptions
- Instructions on follow-up care including date of future preventive care visits must be documented on each visit
- For patients 14 years and older, appropriate notations concerning the use of cigarettes, alcohol and substance abuse (including anticipatory guidance and health education)
- Information on the individuals to be instructed in assisting the patient
- Medical records must be legible, dated and signed by the physician, physician assistant, nurse practitioner or nurse midwife providing patient care
- An immunization record for children that is up-to-date or an appropriate history for adults
- Documentation of attempts to provide immunizations; if the member refuses immunization, proof of voluntary refusal of the immunization in the form of a signed statement by the member or guardian shall be documented in the member's medical record
- Evidence of preventive screening and services in accordance with The Anthem Blue Cross *Preventive Health Guidelines*
- Documentation of referrals, consultations, diagnostic test results and inpatient records; evidence of the provider's review may include the provider's initials or signature and notation in the patient's medical record of the provider's review and patient contact, follow-up treatment, instructions, return office visits, referrals, and other patient information
- Notations of patient appointment cancellations or "no shows" and the attempts to contact the patient to reschedule
- No evidence that the patient is placed at inappropriate risk by a diagnostic test or therapeutic procedure
- Documentation on whether an interpreter was used and, if so, that the interpreter was also used in follow-up
- Documentation of the member's preferred language

MISROUTED PROTECTED HEALTH INFORMATION

Providers and facilities are required to review all member information received from Anthem Blue Cross to ensure no misrouted protected health information (PHI) is included. Misrouted PHI includes information about members that a provider or facility is not treating. PHI can be misrouted to providers and facilities by mail, fax, email or electronic remittance advice. Providers and facilities are required to destroy immediately any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or re-disclose misrouted PHI.

If providers or facilities cannot destroy or safeguard misrouted PHI, please contact the appropriate Customer Care Center in **Chapter 2: Quick Reference**.

MEDICAL RECORDS REVIEW PROCESS

The Anthem Blue Cross QM team will call the provider's office to schedule a medical records

review on a date and time. On the day of the review, the QM staff will:

- Request the number and type of medical records required.
- Review the appropriate type and number of medical records per provider.
- Complete the medical record review.
- Meet with the provider or office manager to review and discuss the results of the medical record review
- Schedule follow-up reviews for any corrective actions identified.

Providers must attain a score of 80% or greater in order to pass the medical record review. A CAP will be required if under 90% to improve future documentation.

Provider sites that score below 80% in the medical record review for two consecutive reviews must score a minimum of 80% in the next review. Sites that don't score a minimum of 80% will be removed from the network, and the provider's members will be appropriately reassigned to other participating providers.

PREVENTABLE ADVERSE EVENTS

The breadth and complexity of today's health care system means there are inherent risks, many of which can be neither predicted nor prevented. However, when there are preventable adverse events, they should be tracked and reduced with the ultimate goal of eliminating them.

Providers and health care systems, as advocates for our members, are responsible for the continuous monitoring, implementation and enforcement of applicable health care standards. Focusing on patient safety, we work collaboratively with network providers and hospitals to identify preventable adverse events and implement appropriate strategies and technologies to avoid them. Our goal is to enhance the quality of care received not only by our members but all patients receiving care in these facilities.

Prevention of adverse events may require the disclosure of PHI. HIPAA specifies that PHI **can** be disclosed for the purpose of health care operations in relation to quality assessment and improvement activities. Moreover, the information you share with us is legally protected through the peer-review process. As such, it will be maintained in a strictly confidential manner. If you receive a request for medical records, please provide them within 10 days from the date of request.

We will continue to monitor activities related to the list of adverse events from federal, state and private payers including **never events**.

Preventable adverse events should not occur. When they do, we firmly support the concept that a health plan and its members should not pay for resultant services.

In the event that Anthem Blue Cross determines that the quality of care or services provided by a health care professional is not satisfactory, as may be evidenced by member satisfaction surveys, member complaints or grievances, medical management data, complaints or lawsuits alleging professional negligence, or any other quality of care indicator, Anthem Blue Cross may exercise any appropriate rights to terminate the Provider Agreement.

Note: Medicaid is prohibited from paying for certain **Health Care Acquired Conditions** (HCAC). This applies to all hospitals.

Never events: As defined by the National Quality Forum (NQF), never events are adverse events that are serious but largely preventable and of concern to both the public and health care providers.

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 Blue Cross benefit plan. These policies can be accessed on our website at:

https://mediproviders.anthem.com/ca/pages/reimbursement-policies.aspx.

The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use 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. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem Blue Cross may:

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

Anthem Blue Cross reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by provider or State contract language, or State, Federal requirements or mandates. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Anthem Blue Cross strives to minimize these variations.

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.

REVIEW SCHEDULES AND UPDATES

Anthem Blue Cross reserves the right to review and revise its policies periodically when necessary.

Reimbursement policies undergo reviews e for updates to state, federal or CMS contracts and/or requirements.

Additionally, updates may be made at any time if we are notified of a mandate change or due to an Anthem Blue Cross business decision. When there is an update, the most current policy will be published on the website provided at the beginning of this section.

REIMBURSEMENT BY CODE DEFINITION

Anthem Blue Cross allows reimbursement for covered services based on their procedure code definition, or descriptor, as opposed to their appearance under particular CPT categories or sections unless otherwise noted by state, federal or CMS contracts and/or requirements. There are seven CPT sections:

1. Evaluation 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 coeds: temporary codes for emerging technology, services or procedure

CLAIM SUBMISSIONS

FILING LIMITS

Claims must be submitted within the contracted filing limit to be considered for payment. Claims submitted after that time period will be denied for timely filing. The provider or hospital shall bill Anthem Blue Cross within 180 days from the date of discharge for inpatient claims and 180 days from the date of service for outpatient and professional claims or Anthem Blue Cross may refuse payment.

Filing limits should be determined as follows:

- If Anthem Blue Cross is the primary payer, use the length of time between the last date of service on the claim and the Anthem Blue Cross receipt date.
- If Anthem Blue Cross is the secondary payer, use the length of time between the other payer's notice and **remittance advice** date and the Anthem Blue Cross receipt date.
- **Note**: Anthem Blue Cross is not responsible for a claim never received. If a claim is submitted inaccurately, prolonged periods before resubmission may cause you to miss the filing deadline. To avoid missing deadlines, submit clean claims as soon as possible after delivery of service. In the event of an inconsistency between information contained in this *Provider Manual* and the *Agreement* between you and Anthem Blue Cross, the *Agreement* shall govern.
- Pursuant to the **California Welfare and Institutions Code (W&I) Section 14115**, DHCS allows for the following four exceptions to the 180-day filing limit:
- If the patient has failed to identify himself or herself as a Medi-Cal beneficiary within four months after the month of service.
- If a provider has submitted a bill to a liable third party, the provider has one year after the month of service to submit the bill for payment.
- If a legal proceeding has commenced in which the provider is attempting to obtain payment from a third party, the provider has one year to submit the bill after the month in which the services have been rendered.
- If Anthem Blue Cross finds that the delay in submission of the bill was caused by circumstances beyond the control of the provider.

CLEAN CLAIMS

Please use the following guidelines when submitting a claim.

- Submit **clean** claims, making sure that the correct and complete information is submitted on the correct form. A clean claim is a request for payment for a service rendered by a provider that:
  - Is submitted timely.
  - Is accurate.
  - Is submitted in a HIPAA-compliant format or using the standard claim form including a *UB-04*, *CMS-1450* or *CMS-1500 (02-12)*, or successor forms thereto, or the electronic equivalent of such claim form.
  - Requires no further information, adjustment or alteration by the provider or by a third party in order to be processed and paid by us.
- Submit claims as soon as possible after providing service.
- Submit claims within the contract filing time limit.

If we do not adjudicate the clean claim within 30 business days, we will pay all applicable interest as required by law. In the event that Anthem Blue Cross does not finalize a clean claim within 30 business days of receipt, interest will be due to the

provider if the claim is payable. Providers are notified of the disposition of a claim with either a *Remittance Advice (RA)* or a *Claims Disposition Notice (CDN)* when the claim is finalized.

Paper claims that are determined to be unclean will be returned to the billing provider along with a letter stating the reason for the rejection. Electronic claims that are determined to be unclean will be rejected to the clearinghouse that submitted the claim. In the event you are a direct electronic submitter to Anthem Blue Cross, the claim will be returned to you directly.

METHODS FOR SUBMISSION

There are two methods for submitting a claim:

- Electronically through Electronic Data Interchange (preferred)
- Paper or hard copy
    - *CMS-1500* for Professional Services
    - *UB-04 (CMS-1450)* for Facility and/or Outpatient Ancillary Services

ELECTRONIC CLAIMS

If the service is the responsibility of Anthem Blue Cross, electronic filing methods are preferred for accuracy, convenience and speed. Electronic submitters will receive electronic acknowledgement of the claim that has been submitted within 24 hours of receipt at Anthem Blue Cross.

Electronic Data Interchange

Anthem has a strategic relationship with Availity to serve as our Electronic Data Interchange (EDI) partner for all electronic data and transactions. You can use your existing Clearinghouse or choose to send direct submissions to Availity. The website for more detail or to register is **www.availity.com**.

(EDI) allows providers and facilities to submit and receive electronic transactions. EDI is available for most common health care business transactions. Please work with your software vendor, management service organization or your clearinghouse to enable electronic transactions.

For EDI claims submissions that require attachments, contact Availity or your clearinghouse for guidelines.

For more information on EDI, providers and vendors may call Availity Client Services at the following phone number-1-800-282-4548. You can also contact this number if you are interested in becoming a direct submitter. You can also email us at the following email address.

EDI Solutions email:
e-Solutions.Support@anthem.com

If you have any questions please contact Availity Client Services at 1-800-Availity (1-800-282-4548) Monday through Friday 8:00 a.m. to 7:30 p.m. Eastern Time

For additional information related to electronic transactions, we have a website dedicated to sharing billing information with providers and EDI vendors including electronic clearinghouses. This information includes details on how to submit, receive and troubleshoot electronic transactions.

To access all EDI manuals, forms and communications, go to:

http://www.anthem.com/edi

The following are available online:

- Availity Quick Start Guide for EDI Submissions
- EDI contacts and support information
- EDI communications and electronic submission tips
- Information on electronic filing benefits and cost savings
- Filing instructions for EDI submission of eligibility, benefit and claim status inquiries
- Anthem Blue Cross *HIPAA Companion Guide* and *EDI User Guide* with complete information on submitting and receiving electronic transactions
- Anthem Blue Cross report descriptions
- FAQ about electronic transactions
- Information and links to the HIPAA website

PAPER CLAIMS

If the service is the responsibility of Anthem Blue Cross and you are unable to submit the claim electronically, please mail paper claims to:

Claims and Billing
Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

If the service is the responsibility if one of our delegated entities, please send the claim to the responsible entity.

Paper claims must be legible and submitted in the proper format. Follow the guidelines below.

- Use the correct form and be sure the form meets CMA standards.
- Use black or blue ink (do not use red ink as the scanner may not be able to read it).
- Use the **Remarks** field for messages.
- Do not stamp or write over boxes on the claim form.
- Send the original claim form to Anthem Blue Cross and retain a copy for your records.
- Separate each individual claim form. **Do not** staple original claims together; Anthem Blue Cross will consider the second claim as an attachment and not an original claim to be processed separately.
- Remove all perforated sides from the form; leave a ¼-inch border on the left and right side of the form after removing perforated sides. This helps our scanning equipment scan accurately.
- Type information within the designated field. Be sure the type falls completely within the text space and is properly aligned.
- Hand written claims need to use all capital letters and do not go outside of boxes into red areas. Use black ink and not markers.
- Don't highlight any fields on the claim forms or attachments; doing so makes it more difficult to create a clear electronic copy when scanned.
- If using a dot matrix printer, do not use draft mode since the characters generally do not have enough distinction and clarity for the optical scanner to read accurately.

If you submit paper claims, you must include the following provider information:

- Provider name
- Rendering provider group or billing provider
- Federal provider tax identification number (TIN)
- National provider identifier (NPI)
- License number (if applicable)
- Medicare number (if applicable)

Note: Some claims may require additional attachments. Be sure to include all supporting documentation when submitting your claim.

A claim may be rejected or denied if it is submitted with incomplete or invalid information. It is the responsibility of the provider to submit accurate and timely information.

CMS-1500 CLAIM FORM FIELDS

We encourage all providers to submit their professional claims to Anthem Blue Cross in an EDI format. In the event you need to submit a paper claim, please submit the most current version of the *CMS-1500* claim form for professional services and *UB-04 (CMS-1450)* for facility and/or some ancillary charges. Before submitting the claim to Anthem Blue Cross, please verify if Anthem Blue Cross is responsible for payment of the service. The service may be delegated to a provider partner of Anthem Blue Cross.

#	Title	Explanation
1	Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA, Black Lung, Other	Indicate the type of health insurance coverage applicable to this claim by placing an X in the appropriate box. Only one box can be marked.
1a	Insured's ID Number	Enter the insured's ID number as shown on insured's ID card for the payer to which the claim is being submitted. If the patient has a unique member identification number assigned by the payer, enter that number in this field.
2	Patient's Name	Enter last name first, then first name and middle initial (if known). Do not use nicknames or full middle names. The ID card and the patient's name must be identical.
3	Patient's Birth Date	Enter the patient's 8-digit date of birth as MM/DD/CCYY.
4	Insured's Name	"Same" is acceptable if the insured is the patient. If the insurance is through a spouse or a parent, enter the insured's name.
5	Patient's Address/Telephone Number	Enter complete address. Include any unit or apartment number. Include abbreviations for road, street, avenue, boulevard, place, etc. The NUCC recommends that the phone number not be reported. Phone extensions are not supported. Do not use punctuation in the address. Temporary addresses are not reported.
6	Patient Relationship to Insured	The relationship to the member such as self, spouse, children or other.
7	Insured's Address/Phone Number	"Same" is acceptable if the insured is the patient. It is not recommended to add the phone number as it is not transmitted over on the 837 file.
8	Reserved for NUCC Use	Leave blank for NUCC use.
9	Other Insured's Name	If there is other insurance coverage in addition to the member's coverage, enter the name of the insured. If the member has a Medigap policy different than that shown in item 2.
9a	Other Insured's Policy or Group Number	Enter the policy and/or group number of the secondary insurance (e.g., Medigap insured preceded by MEDIGAP, MG or MGAP).

#	Title	Explanation
9b	Other Insured's Date of Birth	Enter date of birth in the MM/DD/YY format. If 9d is completed, leave blank.
9c	Employer's Name or School Name	Enter the claims processing address of the Medigap insurer If 9d is completed, leave blank.
9d	Insurance Plan Name or Program Name	Name of plan carrier.
10	Patient's Condition Related To	Include any description of injury or accident including whether it occurred at work.
10a	Related to Employment?	Y or N. If insurance is related to workers compensation, enter Y.
10b	Related to Auto Accident/Place?	Y or N. Enter the state where the accident occurred.
10c	Related to Other Accident?	Y or N.
10d	Reserved for Local Use	Condition codes: Approved for use in this item include codes for abortions, sterilization and codes for workman's compensation claims. When required by payers to provide the subset of condition codes approved by the NUCC, enter the condition code in this field. The condition codes approved for use on the 1500 claim form are available at www.nucc.org under *Code Sets*.
11	Insured's Policy Group of FECA Number, Date of Birth, Sex, Employer or School Name	Complete information about insured, even if same as patient. Medicare requires completion of these fields.
11a	Insured's Date of Birth	Enter the insured's 8-digit birth date (MM/DD/CCYY) and sex if different from item 3. If gender is unknown, leave blank.
11b	Other Claim ID designated by NUCC	When submitting to property and casualty payers (e.g. automobile, homeowner's, or workers' compensation insurers and related entities), the following qualifier and accompanying identifier has been designated for use: Y4 Agency Claim Number (Property Casualty Claim Number). Enter the qualifier to the left of the vertical, dotted line. Enter the identifier number to the right of the vertical, dotted line.
11c	Insurance Plan Name or Program Name	Enter the name of the insurance plan or program of the insured.
11d	Is There Another Health Benefit Plan?	This is marked to indicate if the patient has secondary insurance. If item is marked "YES," items 9, 9a and 9d must also be completed.

#	Title	Explanation
12	Patient or Authorized Person's Signature	The patient's signature is required to authorize release of medical information to process the claim. Enter "Signature on File," "SOF," or legal signature. When legal signature, enter date signed in 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) format. If there is no signature on file, leave blank or enter "No Signature on File." Use the space available to enter signature/information and date.
13	Insured or Authorized Person's Signature	The patient's signature authorizes payment of medical benefits to the physician or supplier.
14	Date of Current Injury, Illness or Pregnancy	Enter an 8-digit (MM/DD/CCYY) or 6-digit (MM/DD/YY) date of current illness, injury or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. 431 Onset of Current Symptoms or Illness-484 Last Menstrual Period.
15	Other Date	Enter another date related to the patient's condition of treatment in either an 8-digit (MM/DD/CCYY) or 6-digit (MM/DD/YY) format. Enter the applicable qualifier to identify which date is being reported. Enter the applicable qualifier to identify which date is being reported.
16	Dates Patient Unable to Work in Current Occupation	If the patient is employed and unable to work in his/her current occupation, enter an 8-digit (MM/DD/CCYY) or 6-digit (MM/DD/YY) date when patient is unable to work. If the patient is treated for a work-related injury, the claim is submitted to worker's compensation and not the patient's medical insurance.
17	Name of Referring Provider or Other Source	Enter the other ID number of the referring, ordering or supervising provider.
17a	Other ID#	The other ID number of the referring, ordering or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a.The NUCC defines the following qualifiers used in 5010A1: 0B State License Number 1G Provider UPIN Number G2 Provider Commercial Number LU Location Number (This qualifier is used for supervising provider only.)
17b	National Provider Number	Enter the NPI of the referring/ordering/supervising physician or nonphysician practitioner listed in item 17b. NPIs are required.
18	Hospitalization Dates Related to Current Services	Enter the inpatient 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) hospital admission date followed by the discharge date (if discharge has occurred). If not discharged, leave discharge date blank. This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Additional Claim Information designated by NUCC	Payers have different uses for this field. "Additional Claim Information" identifies additional information about the patient's condition or the claim.

#	Title	Explanation
20	Outside Lab? $Charges	Complete this item when billing for purchased services by entering an “X” in “YES” (e.g., diagnostic tests subject to the antimarkup payment limitation). This is not used in an ASC. When “YES” is marked, charges are entered to the left of the vertical line. Enter number right justified to the left of the vertical line. Enter “00” for cents if the amount is a whole number. Do not use dollar signs, commas or a decimal point when reporting amounts. Negative dollar amounts are not allowed. Leave the right-hand field blank.
21	Diagnosis or Nature of Illness or Injury	The “ICD Indicator” identifies the version of the ICD code set being reported. The “Diagnosis or Nature of Illness or Injury” is the sign, symptom, complaint or condition of the patient relating to the service(s) on the claim. Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 9 ICD-9-CM 0 ICD-10-CM
22	Resubmission and/or Original Reference Number	Enter the original reference number for resubmitted claims. When resubmitting a claim, enter the appropriate bill frequency. 7 = replacement of prior claim; 8 = void/cancel of prior claim.
23	Prior Authorization Number	The “Prior Authorization Number” is the payer assigned number authorizing the service(s). Enter any of the following: prior authorization number, referral number, mammography precertification number, or Clinical Laboratory Improvement Amendments (CLIA) number, as assigned by the payer for the current service.
24	Supplemental Information	Supplemental information can only be entered with a corresponding, completed service line. The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and another/proprietary identifier and to accommodate the submission of supplemental information to support the billed service. The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service. The supplemental information is to be placed in the shaded section of 24a through 24g as defined in each item number. Providers must verify requirements for this supplemental information with the payer.
24a	Date(s) of Service	“Date(s) of Service” indicates the actual month, day and year the service(s) was provided. Grouping services refers to a charge for a series of identical services without listing each date of service.
24b	Place of Service	The “Place of Service” code identifies the location where the service was rendered. In 24b, enter the appropriate two-digit code from the Place of Service Code list for each item used or service performed. The Place of Service Codes are available at: **https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html**.
24c	EMG	“EMG” identifies if the service was an emergency. Check with payer to determine if this information (emergency indicator) is necessary. If required, enter Y for “YES” or leave blank if “NO” in the bottom, unshaded area of the field. The definition of emergency would be either defined by federal or state regulations or programs, payer contracts or as defined in 5010A1.

#	Title	Explanation
24d	Procedure, Services or Supplies	"Procedures, Services or Supplies" identify the medical services and procedures provided to the patient. Enter the CPT or HCPCS code(s) and modifier(s) (if applicable) from the appropriate code set in effect on the date of service. This field accommodates the entry of up to four two-digit modifiers. The specific procedure code(s) must be shown without a narrative description.
24e	Diagnosis Pointer	The "Diagnosis Pointer" is the line letter from item number 21 that relates to the reason the service(s) was performed. In 24e, enter the diagnosis code reference letter (pointer) as shown in item number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. ICD-10-CM diagnosis codes must be entered in item number 21 only. Do not enter them in 24e.
24f	$Charges	"$Charges" is the total billed amount for each service line. Enter the charge for each listed service.
24g	Days or Units	"Days or Units" is the number of days corresponding to the dates entered in 24a or units as defined in CPT or HCPCS coding manual(s). Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia units or minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered. For anesthesia services based on time, the number of minutes must be reported as t units.
24h	EPSDT Family Plan	For Early and Periodic Screening, Diagnosis and Treatment-related services, enter the response in the shaded portion of the field as follows: Enter "Y" for EPSDT or "N" for non-EPSDT. The following codes for EPSDT are used in 5010A1: AV Available – Not Used (Patient refused referral.) S2 Under Treatment (Patient is currently under treatment for referred diagnostic or corrective health problem.) ST New Service Requested (Referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals.) NU Not Used (Used when no EPSDT patient referral was given.)
24i	ID Qualifier	Enter in the shaded area of 24i the qualifier identifying if the number is a non-NPI. The other ID # of the rendering provider should be reported in 24j in the shaded area. If the provider does not have an NPI number, enter the appropriate qualifier and identifying number in the shaded area. There will always be providers who do not have an NPI and will need to report non-NPI identifiers on their claim forms. The qualifiers will indicate the non-NPI number being reported. The NUCC defines the following qualifiers used in 5010A1: 0B State License Number 1G Provider UPIN Number G2 Provider Commercial Number LU Location Number ZZ Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 claim form.)

#	Title	Explanation
24j	Rendering Provider ID#	The individual rendering the service should be reported in 24j. Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the unshaded area of the field. The individual performing/rendering the service should be reported in 24j and the qualifier indicating if the number is a non-NPI is reported in 24i. The non-NPI ID number of the rendering provider refers to the payer assigned unique identifier of the professional.
25	Federal Tax ID Number	Enter the “Federal Tax ID Number” (employer ID number or SSN) of the billing provider identified in item number 33. This is the tax ID number intended to be used for 1099 reporting purposes. Enter an “X” in the appropriate box to indicate which number is being reported. Only one box can be marked.
26	Patient’s Account No	Enter the patient’s account number assigned by the provider or service’s or supplier’s accounting system. This item is optional to assist the provider in patient identification.
27	Accept Assignment?	Check the appropriate block to indicate whether the provider of service or supplier accepts assignment. Accepting assignment means the provider agrees to the allowed amount (negotiated rate) for the charge.
28	Total Charge	Enter total charges for the services (e.g., total of all charges in 24f). Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter “00” in the cents area if the amount is a whole number.
29	Amount Paid	The “Amount Paid” is the payment received from the patient or other payers. Enter total amount the patient and/or other payers paid on the covered services only.
30	Reserved for NUCC Use	This field is reserved for NUCC use. The NUCC will provide instructions for any use of this field. Leave blank.
31	Signature of Physician or Supplier Including Degrees or Credentials	The “Signature of the Physician or Supplier Including Degrees or Credentials” refers to the authorized or accountable person and the degree, credentials, or title. Enter the signature if provider of service or supplier, or his/her representative, and either an 8-digit (MM/DD/CCYY) or 6-digit (MM/DD/YY) date, or alpha-numeric date the form was signed. This can be completed as “Signature on File” or “SOF” or a computer generated signature.
32	Service Facility Location Information	Enter the name, address, city, state and ZIP code of the location where the services were rendered. Providers of service (namely physicians) must identify the supplier’s name, address, ZIP code and NPI number when billing for purchased diagnostic tests. When more than one supplier is used, a separate 1500 claim form should be used to bill for each supplier.
32a	NPI#	Enter the NPI number of the service facility location in 32a.Only report a service facility location NPI when the NPI is different from the billing provider NPI.

#	Title	Explanation
32b	Other ID#	The non-NPI ID number of the service facility is the payer assigned unique identifier of the facility. Enter the 2-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen or other separator between the qualifier and number. The NUCC defines the following qualifiers used in 5010A1: 0B State License Number G2 Provider Commercial Number LU Location Number
33	Billing Provider Info & Ph #	Enter the provider's or supplier's billing name, address, ZIP code and phone number. The phone number is to be entered in the area to the right of the field title. Enter the name and address information in the following format: 1st Line – Name 2nd Line – Address 3rd Line – City, State and ZIP Code Item 33 identifies the provider that is requesting to be paid for the services rendered and should always be completed.
33a	NPI of Billing Provider	The NPI number refers to the HIPAA national provider identifier number. Enter the NPI number of the billing provider in 33a.
33b	Other ID#	The non-NPI ID number of the billing provider refers to the payer assigned unique identifier of the professional. Enter the 2-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen or other separator between the qualifier and number. The NUCC defines the following qualifiers used in 5010A1: 0B State License Number G2 Provider Commercial Number ZZ Provider Taxonomy (The qualifier in the 5010A1 for provider taxonomy is PXC, but ZZ will remain the qualifier for the 1500 claim form.)

UB-04/CMS-1450 CLAIM FORM FIELDS

We encourage all providers to submit their professional claims to Anthem Blue Cross in an EDI format. In the event you need to submit a paper claim, please submit the most current version of the *CMS-1500* claim form for professional services and *UB-04 (CMS-1450)* for facility and/or ancillary charges. Before submitting the claim to Anthem Blue Cross, please verify if Anthem Blue Cross is responsible for payment of the service. The service may be delegated to a provider partner of Anthem Blue Cross.

#	Title	Explanation
1	Billing Provider Name, Address and Telephone Number	The name and service location provider submitting the bill. The billing provider address must be a street address. Use full nine-digit ZIP code XXXXX-XXXX.
2	Billing Provider's Designated Pay-to Address	The address that the provider submitting the bill intends payment to be sent if different than field 1. Address may include P.O. Box or street name and number, city, state and ZIP. Use 5-digit ZIP code XXXXX.
3a	Patient Control Number	Patient's unique number assigned by the provider to facilitate retrieval of the individual's account of services containing the financial billing records and nay postings of payments.
3b	Medical/Health Record Number	The number assigned to the patient's medical/health record by the provider.
4	Type of Bill	A code indicating the specific type of bill (TOB) (e.g., hospital inpatient, outpatient, replacements, voids, etc.). This is a four-digit code. First digit: leading zero/second digit: type of facility/third digit: bill classification/fourth digit: frequency of the bill
	Federal Tax Number	The number assigned to the provider by the federal government for tax reporting purpose, tax Identification number (TIN) or employer identification number (EIN).
6	Statement Covers Period (From-Through)	The beginning and ending service dates of the period included on this bill. Format: MMDDYY.
7	Reserved for Assignment	Not used
8	Patient Name/Identifier	Last name, first name and middle initial of the patient and the patient identifier as assigned by the payer.
9	Patient Address	The mailing address of the patient. Enter the complete mailing address including street number and name or post office box number or RFD; city name; state; ZIP code.
10	Patient Birth Date	The date of birth of the patient. Format: MMDDYYYY
11	Patient Sex	The sex of the patient as recorded at admission, outpatient service or start of care. Format: M = male; F = female; U = unknown

<table>
<tr><th>#</th><th>Title</th><th>Explanation</th></tr>
<tr><td>12</td><td>Admission/Start of Care Date</td><td>The start date for this episode of care. For inpatient services, this is the date of admission. For other (home health) services, it is the date the episode of care began. Format: MMDDYYYY</td></tr>
<tr><td>13</td><td>Admission Hour</td><td>The code referring to the hour during which the patient was admitted for inpatient care. Enter the hour of admission to the 24-hour (00-23) format. Do not include the minutes.</td></tr>
<tr><td>14</td><td>Priority (Type) of Admission or Visit</td><td>A code indicating the priority of this admission/visit.
<table>
<tr><th>Code</th><th>Type</th><th>Code</th><th>Type</th></tr>
<tr><td>1</td><td>Emergency</td><td>4</td><td>Newborn-born outside hospital</td></tr>
<tr><td>2</td><td>Urgent</td><td>5</td><td>Trauma</td></tr>
<tr><td>3</td><td>Elective</td><td></td><td></td></tr>
</table></td></tr>
<tr><td>15</td><td>Point of Origin for Admission or Visit</td><td>A code indicating the point of patient origin for this admission or visit. UB-04: Required on all bill types except 014x.
<table>
<tr><th>Code</th><th>Type</th><th>Code</th><th>Type</th></tr>
<tr><td>4</td><td>Transfer from a Hospital (Different Facility)</td><td>E</td><td>Transfer from Ambulatory Surgery Center (ASC)</td></tr>
<tr><td>5</td><td>Transfer from a Skilled Nursing Facility (SNF)</td><td>F</td><td>Transfer from a Hospice Facility</td></tr>
<tr><td>6</td><td>Transfer from another Health Care Facility</td><td></td><td></td></tr>
</table></td></tr>
<tr><td>16</td><td>Discharge Hour</td><td>The code referring to the hour during which the patient was admitted for inpatient care. Enter the hour of admission to the 24-hour (00-23) format. Do not include the minutes.</td></tr>
<tr><td>17</td><td>Patient Discharge Status</td><td>A code indicating the disposition or discharge status of the patient at the end of service for the period covered on this bill, as reported in FL6, Statement Covers Period.</td></tr>
<tr><td>18-28</td><td>Condition Codes</td><td>Condition codes are used to identify conditions related to the patient’s bill that may affect payer processing. These codes should be entered from left to right in numeric-alpha sequence starting with the lowest value.</td></tr>
<tr><td>29</td><td>Accident State</td><td>The accident state field contains the two-digit state abbreviation where the accident occurred.</td></tr>
</table>

#	Title	Explanation
30	Reserved for Assignment by the NUBC	Not used.
31-34	Occurrence Codes and Dates	The code and associated date defining a significant event relating to this bill that may affect payer processing. Occurrence codes and dates should be entered from left to right, top to bottom in numeric-alpha order starting with the lowest value.
35-36	Occurrence Span Codes and Dates	A code and the related dates that identify an event that relates to the payment of the claim. These codes identify occurrences that happened over a span of time. Enter all dates as month, day and year (MMDDYY).
37	Reserved for Assignment by the NUBC	Not used.
38	Responsible Party Name and Address (Claim Addressee)	The name and address of the party to whom the bill is being submitted. Address may include post office box or street name and number, city, state and ZIP code. Hospitals should abbreviate state in the address according to the post office standard abbreviations appearing in the instructions for Form Locator 01. The 9-digit ZIP code is used; it should be entered XXXXX-XXXX.
39-41	Value Codes and Amounts	A code structure to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization. Enter value codes and amounts from left to right, top to bottom in numeric-alpha sequence starting with the lowest value. Do not enter a decimal point (.), dollar sign ($), positive (+) or negative (-) sign. Enter full dollar amount and cents, even if the amount is even. Value codes and amounts are used to relate amounts to data elements necessary to process the claim. Value code information is required for Medicare/Medi-Cal crossover claims.
42	Revenue Codes (REV)	Codes that identify specific accommodation, ancillary service or unique billing calculations or arrangements.
43	Revenue Description/IDE Number/Medicaid Drug Rebate	The facility can use this form locator to enter a narrative description or standard abbreviation for each revenue code shown in FL 42 on the adjacent line in FL 43.
44	HCPCS/Accommodation Rates/HIPPS Rate Codes	1. The Healthcare Common Procedure Coding System (HCPCS) applicable to ancillary service and outpatient bills. 2. The accommodation rate for inpatient bills. 3. Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems.
45	Service Date	Enter the date the service was rendered in six-digit format MMDDYY.

#	Title	Explanation
46	Service Units	Enter the actual number of times a single procedure or item was provided for the date of service. If billing for more than 99, divide the units on two or more lines. Inpatient Claims: Enter the number of days of care by revenue code.
47	Total Charges	In full dollar amount, enter the usual and customary fee for the service billed. Do not enter a decimal point (.) or dollar sign ($). Enter full dollar amount and cents, even if the amount is even (e.g., if billing for $100, enter “10000”not “100”).
48	Non-Covered Charges	The total noncovered charges pertaining to the related revenue code in FL 42 are entered here.
49		Not used.
50	Payer Name	Name of health plan that the provider might expect some payment for the bill.
51	Health Plan ID	The number used to identify the payer or health plan.
52	Release of Information Certification Indicator	Code indicates whether the provider has on file a signed statement (from the patient or the patient's legal representative) permitting the provider to release data to another organization.
53	Assignment of Benefits Certification Indicator	Code indicates provider has a signed form authorizing the third-party payer to remit payment directly to the provider.
54	Prior Payments - Payer	The amount the provider has received (to date) by the health plan toward payment of this bill.
55	Estimated Amount Due-Payer	The amount estimated by the provider to be due from the indicated payer (estimated responsibility less prior payments).
56	National Provider Identifier - Billing Provider	The unique identification number assigned to the provider submitting the bill; NPI is the national provider identifier.
57	Other (Billing) Provider Identifier	A unique identification number assigned to the provider submitting the bill by the health plan.
58	Insured's Name	The name of the individual under whose name the insurance benefit is carried.
59	Patient's Relationship to Insured	Code indicating the relationship of the patient to the identified insured.
60	Insured's Unique Identifier	The unique number assigned by the health plan to the insured.

#	Title	Explanation
61	Insured's Group Name	The group or plan name through which the insurance is provided to the insured.
62	Insured's Group Number	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.
63	Authorization Code/Referral Number	An identifier that designates services on this bill have been authorized by the payer or indicates that a referral is involved.
64	Document Control Number (DCN)	The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control.
65	Employer Name (of the Insured)	The name of the employer that provides health care coverage for the insured individual identified in FL 58.
66	Diagnosis and Procedure Code Qualifier (ICD Version Indicator)	The qualifier that denotes the revision of International Classification of Diseases (ICD) reported.
67	Principal Diagnosis Code and Present on Admission Indicator	The ICD diagnosis code, appropriate to the ICD revision indicated in FL 66 describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care).
68		Not used.
69	Admitting Diagnosis Code	The ICD diagnosis code appropriate to the ICD revision indicated in field 66 describing the patient's diagnosis at the time of admission. The reporting of the decimal between the third and fourth character is unnecessary because it is implied. ICD-10 is effective 10/1/2015.
70a-c	Patient's Reason for Visit	The ICD diagnosis codes appropriate to the ICD revision indicated in field 66 describing the patient's stated reason for visit at the time of outpatient registration. The reporting of the decimal between the third and fourth character is unnecessary because it is implied. ICD-10 effective 10/1/2015.
71	Prospective Payment System (PPS) Code	The PPS code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.
72a-c	External Cause of Injury (ECI) Code and Present on Admission Indicator Element	The ICD diagnosis codes appropriate to the ICD revision indicated in field 66 pertaining to the environmental events, circumstances and conditions as the cause of injury, poisoning and other adverse effects. The reporting of the decimal between the third and fourth character is unnecessary because it is implied. ICD-10 effective 10/1/2015.

#	Title	Explanation
73		Not used.
74	Principal Procedure Code and Date	Enter the appropriate ICD-10-PCS code identifying the primary medical or surgical procedure. Enter the ICD-10-PCS code without periods or spaces between the numbers. In 6-digit format, enter the date the surgery or delivery was performed.
74a-e	Other Procedure Codes and Dates	Enter the appropriate ICD-10-PCS code identifying the secondary medical or surgical procedure without period or spaces between the numbers.
75		Not used.
76	Attending Provider Name and Identifiers	Inpatient claim: The attending provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim. Outpatient claim: Enter the referring or prescribing physician's NPI in the first box.
77	Operating Physician Name and Identifiers	Inpatient claim: The name and identification number (NPI) of the individual with the primary responsibility for performing the surgical procedure(s). Do not enter a group provider number. Outpatient claim: Enter the rendering physicians name and identification number (NPI) in the first box.
78-79	Other Provider (Individual) Names and Identifiers	The name and ID number of the individual corresponding to the Provider Type category indicated in this section of the claim. Inpatient claim: Enter the admitting physician's name and individual identification number (NPI).
80	Remarks Field	If additional information cannot be completely entered in this field, attach the additional information to the claim on single-sided 8½ by 11-inch white paper.
81	Code-Code Field	To report additional codes related to a field (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

CLAIMS PROCESSING: DOCUMENT CONTROL NUMBER

All claims accepted by Anthem Blue Cross are assigned a unique **document control number** (DCN). The DCN identifies and tracks claims that are accepted by Anthem Blue Cross. This number contains the Julian date, which indicates the date the claim was received.

Document control numbers are composed of 11 digits:

- 2-digit plan year
- 3-digit Julian date
- 2-digit Anthem Blue Cross reel identification
- 4-digit sequential number

CLAIMS PROCESSING: MCKESSON CLAIMSXTEN

For claims processing, Anthem Blue Cross uses claims editing software from McKesson called ClaimsXten. ClaimsXten incorporates McKesson editing rules that apply plan payment policies.

The rules determine whether a claim should be paid, rejected or require manual processing.

The editing rules evaluate **Current Procedural Terminology** (CPT) and **Healthcare Common Procedure Coding System** (HCPCS) codes on the *CMS-1500* form. A claim auditing action then determines how the procedure codes and code combinations will be adjudicated. The auditing action recognizes historical claims related to current submissions and may result in adjustments to previously processed claims. Providers can refer to **McKesson ClaimsXten™** rules by logging onto **Provider Access**, our secure provider web portal at:

https://provider2.anthem.com/wps/portal/ebpmybcc

ClaimsXten may be updated periodically. Anthem Blue Cross will notify providers with advance notice as per the *Provider Agreement.*

NEWBORNS

Newborns of Medi-Cal members are covered under the mother using the mother's **Client Index Number** (CIN) for the month of birth and the following month or until such time as the California Department of Health Care Services issues a dedicated CIN for the newborn.

CLAIMS CODING AND DOCUMENTATION

Claims submitted with incomplete or invalid information will be rejected or denied and will need to be resubmitted when applicable. Whether you submit a claim electronically or on paper, the claim may be rejected/returned back to the submitter if it contains incomplete or invalid information and or is not deemed a clean claim.

NATIONAL DRUG CODE CODING

Medi-Cal billings for pharmaceuticals dispensed in both professional and institutional settings should include the following information:

- National Drug Codes (NDCs)
- Healthcare Common Procedure Coding System (HCPCS) code
- Unit of measurement
- Unit quantity

When billing for members enrolled in **Medi-Cal**, providers are required to include a **Universal Product Number** (UPN), invoice submissions or for Enteral Medical Billing Number (MBN) for claims involving medical supplies.

INTERNATIONAL CLASSIFICATION OF DISEASES, 10TH REVISION DESCRIPTION

As of October 1, 2015, ICD-10 became the code set for medical diagnoses and inpatient hospital procedures in compliance with HIPAA requirements and in accordance with the rule issued by the U.S. Department of Health and Human Services (HHS).

ICD-10 is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaces the International Classification of Diseases, 9th Revision (ICD-9), which was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes. In the United States, the codes are the foundation for documenting the diagnosis and associated services provided across health care settings.

Although we often use the term ICD-10 alone, there are actually two parts to ICD-10:

- Clinical modification (CM): ICD-10-CM is used for diagnosis coding
- Procedure coding system (PCS): ICD-10-PCS is used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States.

ICD-10-CM replaces the code sets ICD-9-CM, volumes one and two for diagnosis coding, and ICD-10-PCS replaces ICD-9-CM, volume three for inpatient hospital procedure coding.

NATIONAL PROVIDER IDENTIFIER

The **National Provider Identifier** (NPI) is a 10-digit, all numeric identifier. NPIs are only issued to providers of health services and supplies. As a provision of the **Health Insurance Portability and Accountability Act of 1996** (HIPAA), the NPI is intended to improve efficiency and reduce fraud and abuse.

NPIs are divided into two types:

- **Type 1**: individual providers, which includes but is not limited to physicians, dentists and chiropractors
- **Type 2**: hospitals and medical groups, which includes but is not limited to hospitals, residential treatment centers, laboratories and group practices

For billing purposes, claims must be filed with the appropriate NPI for billing, rendering and referring providers. Providers may apply for an NPI online at the link below.

National Plan and Provider Enumeration System (NPPES) website:

https://nppes.cms.hhs.gov

Or, you can get a paper application by calling NPPES at:

NPPES: **1-800-465-3203**

CLINICAL SUBMISSION CATEGORIES

The following is a list of claims categories for which we may routinely require submission of clinical information before or after payment of a claim:

- Claims involving precertification/prior authorization/pre-determination (or some other form of utilization review) including but not limited to:
  - Claims pending for lack of precertification or prior authorization
  - Claims involving medical necessity or experimental/investigative determinations
  - Claims for Injectables requiring prior authorization
- Claims requiring certain modifiers including local code (HCPCS Level III Interim codes if required)
- Claims involving unlisted codes
- Claims for which we cannot determine from the face of the claim whether it involves a covered service; thus, benefit determination cannot be made without reviewing medical records including but not limited to pre-existing condition issues, emergency service-prudent layperson reviews and specific benefit exclusions
- Claims that we have reason to believe involve inappropriate (including fraudulent) billing
- Claims that are the subject of an audit (internal or external) including high-dollar claims
- Claims for individuals involved in case management or disease management
- Claims that have been appealed (or that are otherwise the subject of a dispute including claims being mediated, arbitrated or litigated)

Other situations in which clinical information might routinely be requested:

- Accreditation activities
- Coordination of benefits
- Credentialing
- Quality improvement/assurance efforts
- Recovery/subrogation

Examples provided in each category are for illustrative purposes only and are not meant to represent an exhaustive list within the category.

BILLING REQUIREMENTS FOR PROFESSIONAL, INSTITUTIONAL AND ANCILLARY CLAIMS

HIPAA compliant code sets must be used.*

HCPCS is an acronym for Healthcare Common Procedure Coding System. Standardized code sets are necessary for Medicare and other health insurance providers to provide health care claims that are managed consistently and in an orderly manner. HCPCS Level II coding system is one of several code sets used by health care professionals including medical coders and billers. The Level I HCPCS code set includes CPT codes. CPT is developed and owned by the American Medical Association (AMA).

CPT codes are the United States' standard for how medical professionals document and report medical, surgical, radiology, laboratory, anesthesiology, and evaluation and management (E/M) services. All health care providers, payers and facilities use CPT codes.

HIPAA compliant codes fall into three categories:

- Category I (CPT codes): These five-digit codes have descriptors which correspond to a procedure or service. Codes range from 00100-99499.
    - **Modifier and/or revenue codes**: Use modifier and revenue codes when appropriate with the corresponding HCPCS or CPT codes.
- Category II (HCPCS): These alphanumeric tracking codes are used for execution measurement.
- Category III (interim/temporary codes): These are provisional codes for new and developing technology, procedures, and services. The codes were created for data collection and assessment of new services and procedures.*

* In addition to the HIPAA-compliant codes, the California Department of Health Care Services (DHCS) created a separate set of codes and modifiers for its Medi-Cal program, sometimes called Category III — Interim **(local codes)**. These codes and modifiers identify services and products specific to **Medi-Cal**.

Mid-level practitioners: Indicate the name and license number in Box 19 of the *CMS-1500* form; the supervising physician's license number should be entered in Box 24j. The following are defined as mid-level:

- Physician assistants
- Nurse practitioners
- Certified nurse midwives
- Licensed midwives

Prior Authorization Number: Indicate the prior authorization number in Box 23 of the *CMS-1500* form.

There are certain exceptions to the prior authorization requirement. Professional and facility claims for emergency services are not denied due to lack of prior authorization. Emergency services are determined by diagnosis codes and/or services billed.

Member ID Number: Use the member's **Client Index Number** (CIN) when billing, whether submitting electronically or on paper. It is important to use the member's plan ID card number, **not** the number on the identification card issued by the state.

On-Call Services: Insert **On-Call** for PCP in Box 23 of the *CMS-1500* form when the rendering physician is not the PCP but is covering for or has received permission from the PCP to provide services that day.

Note: When a provider/facility's reimbursement is affected by a contract change during a course of treatment, the provider/facility is required to split the dates of service if you are a per-diem contracted provider/facility. This will allow your claim to be reimbursed at the appropriate rate.

REPORTING PROVIDER PREVENTABLE CONDITIONS ON PRESENT ON ADMISSION CLAIMS

Medi-Cal providers are required to report provider-preventable conditions (PPCs) with POA claims. This reporting is required for claims for Medi-Cal payment or when treatment is given to a Medi-Cal member for which payment would be available.

Providers do not need to report PPCs that existed before the provider initiated treatment for the Medi-Cal member. The new federal regulations prevent Anthem Blue Cross from paying providers for the treatment of PPCs. To ensure compliance, DHCS will investigate all reports of PPCs to determine if payment adjustment is necessary.

Please note: Reporting PPCs for a Medi-Cal member does not prevent or exclude the reporting of adverse events to the California Department of Public Health pursuant to Health and Safety Code Section 1279.1.

Scope of POA and PPC Claims

The following is a list of preventable conditions where payment is prohibited:

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and trauma
    - Fractures
    - Dislocations
    - Intracranial injuries
    - Crushing injuries
    - Burns
    - Electric shock
- Manifestations of poor glycemic control
    - Diabetic ketoacidosis
    - Nonketotic hyperosmolar coma
    - Hypoglycemic coma
    - Secondary diabetes with ketoacidosis
    - Secondary diabetes with hyperosmolarity
- Catheter-associated urinary tract infection (UTI)
- Vascular catheter-associated infection
- Surgical site infection following:
    - Coronary artery bypass graft (CABG) — mediastinitis
    - Bariatric surgery
- Laparoscopic gastric bypass
- Gastroenterostomy
- Laparoscopic gastric restrictive surgery
    - Orthopedic procedures
- Spine
- Neck
- Shoulder
- Elbow
- Deep vein thrombosis (DVT)/pulmonary embolism (PE) (not included for Medicaid for pediatric and obstetric populations)
    - Total knee replacement
    - Hip replacement

Additionally, Anthem Blue Cross may not pay for the following events:

- Surgery on the wrong patient
- Wrong surgery on a patient
- Wrong site surgery

The below Table of Indicator Codes for PPC forms includes the codes to be used on the PPC form. Using the codes correctly ensures you are reimbursed as appropriate.

Indicator	Description	Reimbursable
Y	The condition was present on admission.	Yes
N	The condition was not present on admission.	No
W	The provider determined that it was not possible to document if the condition was present on admission.	Yes
U	The documentation was insufficient to determine if he condition was present on admission.	No

CLAIM PROCESSING

CLAIMS RETURNED FOR ADDITIONAL INFORMATION

Anthem Blue Cross may send you a request for additional or corrected information when the claim cannot be processed due to incomplete, missing or incorrect information. The request will indicate how long you have to return the information to Anthem Blue Cross.

CAPITATED GROUP CLAIMS PROCESSING

When claims processing is a delegated activity, Anthem Blue Cross oversees the processing and dispute resolution to ensure that both are conducted in a timely manner and in accordance with state/federal regulations and contractual agreements.

Groups must have written procedures for claims processing available for review.

These procedures are outlined in your *Anthem Blue Cross State Sponsored Business Group Agreement*. These procedures and disclosures must comply with state/federal laws and regulations and our contractual standards and requirements. They must also be made available upon request by Anthem Blue Cross or a regulatory agency.

Group claims processing systems must identify and track all claims activities including claims disputes and resolutions, and be able to deliver monthly reports. Groups must be able to identify and acknowledge the receipt of each claim, whether or not complete, and disclose the recorded date of receipt in the same manner as the claim was submitted.

- If the claim was received electronically, the group must provide acknowledgement within two business days of receipt of the claim.
- If the claim was a paper claim, the group must provide acknowledgement within 15 business days of receipt of the claim.

Groups must pay a clean claim (or a portion thereof) or contest or deny a claim (or a portion thereof) within 45 business days of receipt of the claim (or within contractual time frames, which comply with the time frames set forth in this section). The group's request for additional information must be sent to the provider of service with a due date for the requested information.

- Payment of a clean claim or notification of a denial must be sent, accompanied by a remittance advice (RA), to the provider of service within 45 business days of the date a claim is received.
- The date of payment or notification of denial is the postmarked date of the payment.
- The provider and member must be notified if a claim is denied, adjusted or contested. The notification must include an understandable written explanation of the reasons for the denial, adjustment or contested elements.

Groups must have a dispute resolution mechanism in place that allows providers to file a dispute within 365 days of receipt of an RA. All disputes must be resolved within 45 business days of the group's receipt of the dispute or as required by applicable state/federal law. Check out IPA contract language.

If a group determines that a claim was overpaid, the group must notify the provider in writing of the overpayment.

- The written notice must identify the claim, the name of the member, the date of service and a clear explanation of the basis upon which the group believes the amount paid was in excess of the amount due including interest and penalties.
- Providers have 30 days from the receipt of the notice of the overpayment to contest or reimburse the overpayment.

The responsibility for claims payment as outlined above continues until all claims have been paid or denied for services rendered pursuant to your *Anthem Blue Cross State Sponsored Business Group Agreement*.

For questions related to delegation of claims processing activities, contact your group administrator.

ELECTRONIC REMITTANCE ADVICE

Anthem Blue Cross offers secure electronic delivery of remittance advices, which explain claims in their final status. This service is offered through **Electronic Data Interchange** (EDI). For more information, providers and vendors may call the EDI Solutions Helpdesk.

☎ EDI Solutions Helpdesk:**1-800-470-9630**

ELECTRONIC FUNDS TRANSFER

Anthem Blue Cross allows **Electronic Funds Transfer** (EFT) for claims payment transactions. This means that claims payments can be deposited directly into a previously selected bank account. Providers can enroll in this service by contacting the **EDI Solutions Helpdesk**.

COORDINATION OF BENEFITS/ THIRD-PARTY LIABILITY

Anthem Blue Cross may coordinate benefits with any other health care program that covers our members including Medicare. Indicate other coverage information on the appropriate claim form. If there is a need to coordinate benefits, include at least one of the following items from the other health care program when submitting a **Coordination of Benefits** (COB) claim:

- Third-party Remittance Advice (RA)
- Third-party provider Explanation of Benefits (EOB)
- Notice from third party explaining the denial of coverage or reimbursement

COB claims received without at least one of these items will be mailed back to you with a request to submit to the other health care program first. Please make sure that the information you submit **explains all coding** listed on the other carrier's RA or letter. We cannot process the claim without this specific information.

The filing limits for COB claims are as follows:

- 180 days: for hospitals, institutions and professional services providers
- 365 days: for ancillary service providers
- Claims follow-up resubmissions are subject to the 90-day resubmission filling limit

CLAIMS STATUS

Claims status can be monitored by doing the following:

- Monitor claim status online via **Availity** at
  - **www.availity.com.**
  - See **Chapter 2** for login instructions
- Monitor claim status through the **Customer Care Center's Interactive Voice Response** (IVR) at the contact numbers listed at the beginning of this chapter.

Note: The Interactive Voice Response (IVR) accepts either your National Provider Identifier (NPI) or your Federal Tax Identification Number (TIN) for provider ID. Should the system not accept those numbers, it will redirect your call to the Customer Care Center. For purposes of assisting you, we may ask again for your TIN.

CLAIMS FOLLOW-UPS/RESUBMISSIONS

Providers can initiate a follow-up to determine claim status by going online to our provider portal and the **Availity Health Information Network**.

When resubmitting a claim, take the following steps:

1. Complete all required fields as originally submitted and mark the change(s) clearly.
2. Write or stamp "Corrected Claim" across the top of the form.
3. Attach a copy of the RA/EOB and state the reason for resubmission.
4. Attach all supporting documentation.
5. Send to:

   Anthem Blue Cross
   P.O. Box 60007
   Los Angeles, CA 90060-0007

OVERPAYMENT AND RECOVERY

Anthem Blue Cross seeks recovery of all excess claims payments from the person or entity to whom the benefit check is made payable. When an overpayment is discovered, Anthem Blue Cross initiates the overpayment recovery process by sending written notification.

If you are notified by Anthem Blue Cross of an overpayment or discover that you have been overpaid, mail the check along with a copy of the notification or other supporting documentation within 30 days to the following address:

Anthem Blue Cross
Overpayment Recovery
P.O. Box 73651
Cleveland, OH 44193-1177

If Anthem Blue Cross does not hear from you or receive payment within 30 days, the overpayment amount is deducted from future claims payments. In cases where Anthem Blue Cross determines that recovery is not feasible, the overpayment is referred to a collection service.

ENCOUNTER DATA

QUALITY MEASURES FOR ENCOUNTER DATA

On January 1, 2015, the California Department of Health Care Services (DHCS) implemented a Quality Measures for Encounter Data (QMED) program for managed care organizations in the state. As a result, Anthem Blue Cross implemented new quality standards for encounter submissions and medical records. These standards relate to:

- Data completeness
- Data accuracy
- Data reasonability
- Data timeliness

Note: These new standards do not supersede the current claims timely filing requirements for fee-for-service claim submissions.

DATA COMPLETENESS AND DATA ACCURACY

Under the QMED program, the DHCS Audits and Investigations Division (A&I) will draw a random sample from the encounters submitted and request the corresponding medical records from the provider to check for data completeness. In addition, DHCS will randomly select a second medical record for the same beneficiary (if applicable) to verify if a corresponding encounter is in the DHCS data warehouse. This subsequent medical record will also be audited for data completeness.

In an encounter data validation study commissioned by DHCS, key data elements were evaluated for data completeness. The study found a lack of correlation between the medical records and corresponding encounter records. Providers are required to submit complete and accurate data elements, and Anthem Blue Cross will begin auditing medical records to assess data completeness and accuracy.

DATA COMPLETENESS

Encounter data is complete when it includes the following:

- Correct billing provider name
- Correct date of service
- Complete beneficiary information

DATA ACCURACY

Accurate encounter data means:

- Correct rendering provider data
- Correct diagnosis codes(s)
- Correct procedure code(s)
- Correct procedure code modifier(s)
- Correct NDC match for J3490/J3590

DATA REASONABILITY

Encounter data is reasonable when both the individual data and the data as a whole include valid dates and accurate information. To ensure the accuracy and acceptability of encounter data, providers must use valid national standard codes for procedure codes, revenue codes and diagnosis codes. Providers must ensure a valid National Provider Identifier (NPI) is used for billing provider, rendering provider, referring provider and prescribing provider.

DATA TIMELINESS

The QMED program will also measure data timeliness, or the lag-time, in days, between the date of service (DOS) and the claims submission date. The DOS refers to the last date of service at the claim level or the first date of service if the last date of service is null. Providers are expected to submit encounter data no less than weekly to Anthem Blue Cross, whether a provider utilizes a clearinghouse or submits encounter data directly to Anthem Blue Cross. Do not delay, submit your encounter immediately following the service to ensure timely handling of the data.

Contracted providers are required to submit encounter data to Anthem Blue Cross according to the following guidelines:

- 65% of encounters submitted (and accepted) within 60 calendar days of DOS (lag time of 0-60 days).
- 80% of encounters submitted (and accepted) within 150 calendar days of DOS (lag time of 0-150 days).
- 95% of encounters submitted (and accepted) within 335 calendar days of DOS (lag time of 0-335 days).

Another timeliness measurement is timely handling of rejection reports. Anthem Blue Cross now requires contracted providers to respond to rejection reports as soon as providers receive them and will measure this process as follows:

- 50% of denied encounters are corrected and submitted (and accepted) within seven calendar days of being denied.
- 80% of denied encounters are corrected and submitted (and accepted) within 15 calendar days of being denied.
- 95% of denied encounters are corrected and submitted (and accepted) within 30 calendar days of being denied.

COMPLETENESS THRESHOLD

The QMED program includes an Encounter Completeness threshold by county for each aid code (ACA optional expansion, Adult, Child, and SPD) as well as category of service (combined outpatient and ER, inpatient, pharmacy, and professional) for encounter submissions. These DHCS-required thresholds are based on data from annualized encounters per thousand members and are subject to change when DHCS revises each

respective threshold. Providers are required to submit encounters in accordance with the thresholds. Anthem will notify providers as the thresholds are updated by DHCS.

If you have any questions, please contact your regional health plan at:

- ☎ Fresno/Madera: **1-559-353-3500**
- ☎ Los Angeles: **1-866-465-2272**
- ☎ Sacramento/Bay Area: **1-916-589-3030**
- ☎ Tulare/Kings: **1-559-623-0480**

Providers have the right to file a dispute with Anthem Blue Cross for denial, deferral or modification of a claim disposition or post-service request.

Providers also have the right to appeal on behalf of a member for denial, deferral or modification of a prior authorization or request for concurrent review. These appeals are treated as member appeals and follow the member appeals process.

Note: Anthem Blue Cross does not discriminate against providers or members for filing a grievance or an appeal. Providers are prohibited from penalizing a member in any way for filing a grievance.

Provider grievances and appeals are classified into the following two categories:

1. Grievances relating to the operation of the plan including benefit interpretation, claim processing and reimbursement
2. Provider appeals of claim determinations including medical reviews related to adverse benefit determinations

Member grievances and appeals can include but are not limited to the following:

- Access to health care services
- Care and treatment by a provider
- Issues having to do with how we conduct business

CLAIM PAYMENT DISPUTE

If you are not satisfied with the outcome of a claim payment decision, you may begin the claim payment dispute process.

The claim payment dispute process consists of the following **linear** steps:

1. Reconsideration
2. Claim payment appeal

Please be aware there are three common, claim-related issues that are not considered claim payment disputes. To avoid confusion with claim payment disputes, we've defined them briefly here:

Claim Inquiry: A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but the 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. Just call:

☎ Medi-Cal Customer Care Center:
1-800-407-4627 (outside L.A. County)

☎ Medi-Cal Customer Care Center:
1-888-285-7801 (inside L.A. County)

☎ MRMIP Customer Care Center:
1-877-687-0549

and select the *Claims* prompt within our voice portal. We connect you with a dedicated resource team, called the Customer Care Center, 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 CCC is available to assist you in determining the appropriate process to follow for resolving your claim issue.

Claim Correspondence: is different from a payment dispute. Correspondence is when Anthem Blue Cross requires more information 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.

Medical Necessity Appeals: Medical necessity appeals refer to a situation in which an authorization for a service was denied prior to the service. Medical necessity appeals/prior authorization appeals are

different than claim payment disputes and should be submitted in accordance with the medical necessity appeal process.

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

- Contractual payment issues.
- Disagreements over reduced or zero-paid claims.
- 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.*

* We will consider reimbursement of a claim that 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.

CLAIM PAYMENT RECONSIDERATIONS

Anthem Blue Cross encourages you to submit a claim reconsideration if you believe a claim was not processed correctly. Please submit your request for claim reconsideration in writing and include all pertinent information that will help us understand the issue. **We must receive your request for reconsideration within 12 months of the last action on a claim.**

Upon receipt of your reconsideration request, an acknowledgement letter will be sent to you within 15 business days of our receipt. We will conduct an internal review that includes a thorough investigation of the claim payment by a trained analyst utilizing all applicable statutory, regulatory, contractual and provider subcontract provisions, Anthem Blue Cross policies and procedures, and all pertinent facts submitted from all parties.

The results will then be communicated to you in a determination letter within 45 business days of the receipt of the reconsideration. If the outcome of the reconsideration requires an adjustment to a claim payment, the adjustment will take place within 15 business days of the reconsideration decision.

CLAIM PAYMENT APPEAL

If you are unsatisfied with the outcome of the reconsideration, you may submit a claim payment appeal within **60 calendar days** of the reconsideration outcome. Please submit your claim payment appeal in writing and please include as much information as is pertinent to help us better understand why you are appealing the decision.

A provider has **30 calendar days** to resubmit the appeal when missing information is requested.

Note: Some providers may have additional time to submit an appeal based upon their contract with Anthem Blue Cross.

Upon receipt of your claim payment appeal, an acknowledgement letter will be sent to you within 15 business days of our receipt. We will conduct an internal review that includes a thorough investigation of the appeal by a trained claims appeal analyst utilizing all applicable statutory, regulatory, contractual and provider subcontract provisions, Anthem Blue Cross policies and procedures, and all pertinent facts submitted from all parties.

The results will then be communicated to you in a determination letter within 45 business days of the receipt of the claim payment appeal. If the outcome of the claim payment appeal requires an adjustment to a claim payment, the adjustment will take place within 15 business days of the reconsideration decision.

SUBMISSION OF DISPUTES

You may submit Reconsiderations and Claim Payment Appeals through

the Availity Payment Appeal Tool at **https://www.availity.com**.

Through Availity, you can upload supporting documentation and will receive immediate acknowledgement of your submission.

You may use the ***Provider Resolution Request Form*** on our website using the address below to submit a reconsideration or claim payment appeal.

https://mediproviders.anthem.com/ca/pages/forms.aspx

Please submit requests for reconsideration or claim payment appeals to:

Claims Payment Reconsideration Department
Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

REQUIRED DOCUMENTATION FOR CLAIMS PAYMENT DISPUTES

Anthem Blue Cross 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 his or her Anthem or Medicaid ID number
- A listing of disputed claims, which should include the Anthem claim number and the date(s) of service(s)
- All supporting statements and documentation

PROVIDER GRIEVANCES

A provider may be dissatisfied or concerned about another provider, a member or an operational issue including claims processing and reimbursement. Provider grievances may be submitted orally or in writing and include the following:

- Provider's name
- Date of the incident
- Description of the incident

Provider grievances may be filed up to 180 calendar days from the date the provider became aware of the issue.

If a provider or member has a grievance, Anthem Blue Cross would like to hear from them either by phone or in writing. Grievances may be filed by calling the Customer Care Center or in writing and submitted to the Grievance and Appeal department. Providers may file a written grievance by using the ***Physician/Provider Grievance Form*** located on our website at the following address.

https://mediproviders.anthem.com/ca/pages/forms.aspx

To mail the form, use the following address:

Grievance and Appeal Department
Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

Providers can also fax the form to:

☎ **1-866-387-2968**

Anthem Blue Cross will send a written acknowledgement to the provider within **five calendar days** of receiving a grievance. We may request medical records or an explanation of the issues raised in the grievance in the following ways:

- By telephone
- By fax with a signed and dated letter
- By mail with a signed and dated letter

The timeline for responding to the request for more information is as follows:

- **Standard grievances**: Providers must comply with the request for additional information within **10 calendar days** of the date that appears on the request.

Providers are notified in writing of the resolution including their right of appeal if any. According to state law, we may not be able to disclose the final disposition of certain grievances due to peer review confidentiality laws.

Anthem Blue Cross sends a written resolution letter to the provider within **30 calendar days** of the receipt of the grievance.

Grievances are tracked and trended, resolved within established time frames, and referred to peer review when necessary. The Anthem Blue Cross grievance and appeal process meets all requirements of state law and accreditation agencies.

Note: Anthem Blue Cross offers an expedited grievance and appeal process to members for decisions involving urgently needed care. Whether standard or expedited, grievances and appeals are reviewed by a person who is not subordinate to the initial decision-maker.

ARBITRATION

If the provider is not satisfied with the outcome of a review conducted through the provider appeal process, there are additional steps that can be taken through arbitration in accordance with the *Anthem Blue Cross State Sponsored Business Provider Agreement*.

For more information, please call the appropriate Customer Care Center at the contact numbers listed in **Chapter 2** of this manual.

MEMBER APPEALS AND GRIEVANCES

We encourage Anthem Blue Cross members to seek resolution of issues through our grievance and appeal process. The issues may involve dissatisfaction or concern about a contracted provider or the plan.

Note: Anthem Blue Cross does not discriminate against members for filing a grievance or an appeal. Providers are prohibited from penalizing a member in any way for filing a grievance.

To help ensure that our members' rights are protected, all Anthem Blue Cross members are entitled to a grievance and appeal process.

Members may request a grievance or an adverse benefit determination appeal by calling our Customer Care Center at:

☎ Medi-Cal Customer Care Center:
1-800-407-4627 (outside L.A. County)

☎ Medi-Cal Customer Care Center:
1-888-285-7801 (inside L.A. County)

☎ MRMIP Customer Care Center:
1-877-687-0549

If a member wants to file a grievance, the process is to call the Customer Care Center, write a letter to the Grievance and Appeal department, or fill out a *Member Grievance Form* and mail it to us, telling us about the problem.

Grievance forms are available at the places where members receive their health care, such as their PCP's office, as well as on our website at:

https://mss.anthem.com/ca/pages/medi-cal.aspx

1. Select **Other Resources** (drop-down menu in the bottom right of the page).
2. Select the language of the *Member Grievances Form*.

The grievance form should be mailed to:

Grievance and Appeal Department
Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

A person does not need to be a member to file a grievance or appeal. Other representatives may include the following:

- Relative
- Guardian
- Conservator
- Attorney
- Member's provider

The grievance submission must include the following information:

- Who is part of the grievance
- What happened
- When it happened
- Where it happened
- Why the member was not happy with the health care services
- Attach documents that will help us look into the problem

If the member cannot mail the form or letter, we will assist the member by documenting a verbal request.

Note: If the member's grievance is related to an **adverse benefit determination** already taken, it is considered an **appeal**.

Adverse benefit determinations may include the following:

- Denial or limited authorization of a requested service including the type or level of service
- The reduction, suspension or termination of a previously authorized service
- The denial, in whole or in part, of payment for service
- Failure to provide services in a timely manner as defined by the state
- Failure of Anthem Blue Cross to act within required time frames

Filing Timelines for the Member Grievance and Appeal Process:

Member grievance	Anytime
Member appeal: Medi-Cal	60 calendar days after the date of the letter notifying the member of a denial, deferral or modification of a request for services
Member appeal: MRMIP	180 calendar days after the date on the letter notifying the member of a denial, deferral or modification of a request for services

Note: Anthem Blue Cross will resolve any grievance or appeal, internal or external, at no cost to the member. Interpreter services and translation of materials into non-English languages and alternative formats are available to support members with the grievance and appeal process at no cost to the member.

MEMBER GRIEVANCES AND APPEALS: ACKNOWLEDGEMENT

After we receive a member's request, we will send an acknowledgment letter within **five calendar days** from the date we receive it.

If we receive a request for an **expedited** grievance or appeal, the Medical Director will review the request to determine if the request involves an imminent and/or serious threat to the health of the member including but not limited to severe pain and potential loss of life, limb or major bodily function. This determination is made within **one working day** of the receipt of the expedited request.

When the Medical Director determines that a case meets the criteria to be handled as an expedited or standard request, attempts to notify the member of the decision are made by telephone. In addition, an acknowledgement letter is sent to the member

indicating the decision to handle as expedited or standard.

If a request is determined to be appropriate for expedited handling, the acknowledgement letter includes the member's right to immediately notify the **Department of Managed Health Care** (DMHC) of the expedited appeal and informs the member of the time available for providing information and that limited time is available for expedited appeals.

MEMBER GRIEVANCES AND APPEALS: RESOLUTION

Anthem Blue Cross may request additional information from the involved providers by phone, mail or fax. The requests may include a request for additional medical records or an explanation from the provider(s) involved in the case. Providers are expected to comply with requests for additional information within 10 calendar days for standard grievances and appeals and within 24 hours for an expedited grievance or appeal.

The member will receive a *Grievance Resolution Letter* within 30 calendar days of the date we received the grievance.

Standard appeals are resolved within **30 calendar days** from the date of receipt of the request. Members are notified in writing of the appeal resolution including their right to further appeal if any. The request for an appeal may be done orally but must be followed up with a written request.

Anthem Blue Cross resolves expedited appeals as quickly as possible and within **72 hours**. The member is notified by telephone of the resolution, if possible, and is also sent a written resolution letter within **72 hours** from receipt of the appeal request.

OTHER OPTIONS FOR FILING GRIEVANCES

Members may submit a request to the following entities:

- Los Angeles County members only: L.A. Care Health Plan
- Medi-Cal Managed Care Office of the Ombudsman at the California Department of Health Care Services

INDEPENDENT MEDICAL REVIEW

After exhausting The Anthem Blue Cross grievance and appeal process, if a member is still dissatisfied with a decision, the member has the right to request an **independent medical review** (IMR) from the following entities:

- **California Department of Managed Health Care:** Members may request an IMR if eligible for an expedited review or an urgent grievance or appeal.

Note: If the member has requested a state fair hearing, he or she cannot also request an IMR.

MEDI-CAL MEMBER APPEALS: STATE FAIR HEARING

The state fair hearing process is applicable to Medi-Cal enrollees only. Anthem Blue Cross members enrolled MRMIP **may not** request a state fair hearing. However, they **may** request an IMR.

Medi-Cal members may request a state fair hearing with the California Department of Social Services (CDSS) after exhausting The Anthem Blue Cross appeal processes, or if Anthem Blue Cross fails to resolve an appeal request within the required time frames.

The state fair hearing must be filed within 120 days from the date of the Notice of Appeal Resolution. The request may be submitted by writing to the state of California at:

Department of Social Services
State Hearing Division
P.O. Box 944243, MS19-37
Sacramento, CA 94244-2430

By calling the department toll free at:

☎ **1-800-952-5253**.

Or submitting an online request

Request a Hearing Online

Note: An IMR with the Department of Managed Health Care (DMHC) may not be requested if a state fair hearing has already been requested for a Notice of Adverse Benefit Determination.

Once the state receives the member's request, the process is as follows:

- The state sends a notice of the hearing request to Anthem Blue Cross.
- Upon receipt of the request, all documents related to the request and are forwarded to the state.
- The state notifies all parties of the date, time and place of the hearing. Representatives from our administrative, medical and legal departments may attend the hearing to present testimony and arguments. Our representatives may cross-examine the witnesses and offer rebutting evidence.
- An **administrative law judge** renders a decision in the hearing within 90 business days of the date the hearing request was made.
- If the judge overturns The Anthem Blue Cross position, we must adhere to the judge's decision and ensure that it is carried out.

MEMBER GRIEVANCES AND APPEALS: DISCRIMINATION

Members who contact us with an allegation of discrimination are immediately informed of the right to file a grievance. This also occurs when one of our representatives working with a member identifies a potential act of discrimination. The member is advised to submit an oral or written account of the incident and is assisted in doing so if he or she requests assistance.

We document, track and trend all alleged acts of discrimination. A Grievance and Appeal associate will review and trend cultural and linguistic grievances in collaboration with a cultural and linguistic specialist.

MEDI-CAL MEMBER APPEALS: CONTINUATION OF BENEFITS FOR ANTHEM BLUE CROSS MEMBERS DURING AN APPEAL

Medi-Cal members may continue benefits while their appeal or state fair hearing is pending in accordance with federal regulations when all of the following criteria are met:

- Member or his provider on the member's behalf must request the **appeal** within **10 days** of our mail date of the adverse action notification or prior to the effective date on the written notice of the adverse action.
- The **appeal** involves the termination, suspension or reduction of a previously authorized course of treatment.
- Services were ordered by an authorized provider.
- The original period covered by the initial authorization has not expired, and member requests extension of benefits.

PROVIDER'S ROLE IN COMPLIANCE, ETHICS, PRIVACY AND HOTLINE REPORTING

STANDARDS OF ETHICAL BUSINESS CONDUCT

The Anthem Blue Cross values drive our ethics program, and we expect our providers to embody these same values as you interact with our members.

The Anthem Blue Cross core values are:

- Leadership – Redefine what's possible.
- Community – Committed, connected, invested.
- Integrity – Do the right thing, with a spirit of excellence.
- Agility – Deliver today – transform tomorrow.
- Diversity – Open your hearts and minds.

☎ You may call the Anthem Blue Cross Ethics and Compliance Help Line to report potential misconduct: **1-877-725-2702**

Anthem code of conduct is located at: **http://anthem.cmpsystem.com/file.php/1/public/SOEBC.pdf**

ANTHEM BLUE CROSS COMPLIANCE PROGRAM

Compliant operations help our members receive the care they need. We have robust processes and oversight of our operations and we expect the same from our providers.

Anthem Blue Cross follows the 7 Elements of an effective compliance program. One of those elements is auditing and monitoring. We routinely monitor a variety of processes including grievances and appeals to understand providers' performance.

We also use a risk assessment approach to determine the actions of our compliance associates. If our risk assessment or monitoring indicates potential noncompliance, we will conduct an investigation.

When there is a compliance violation, we require a corrective action plan with management actions that mitigate risks and prevent further occurrence. As part of any investigation, we require that providers cooperate with the investigation and provide access to pertinent member records.

The Department of Health and Human Services, Office of Inspector General (OIG) has published a notice to assist physician practices in developing a voluntary compliance program.

OIG Compliance Program for Individual and Small Group Physician Practices: **https://oig.hhs.gov/authorities/docs/physician.pdf**

SCREENING AND MONITORING EXCLUDED PARTIES

In our role as a government health care program contractor, Anthem Blue Cross may not employ or contract with individuals or companies that are barred from taking part in such programs or receiving funds from such programs.

To meet this obligation, Anthem Blue Cross screens our providers against exclusion lists kept by the OIG, General Services Administration (GSA) and the Department of Health Care Services (DHCS) Suspended and Ineligible Provider List. We expect our providers to also screen and monitor their staff on a regular, periodic basis. Providers should notify Anthem within 10 working days of removing a suspended, excluded, or terminated provider from its Provider Network.

MARKETING RULES

The delivery of quality health care poses numerous challenges, not least of which is the commitment shared by Anthem Blue Cross and its providers to protect our members.

Anthem Blue Cross wants its members to make the best health care decisions possible for themselves and their families. And when they ask for our assistance, we want to help them make those decisions without undue influence.

Anthem Blue Cross follows strict enrollment and marketing guidelines created by the California DHCS.

ENROLLMENT POLICIES

Anthem Blue Cross providers may not market directly to individuals or families.

An example of direct marketing that is not allowed is mailing to individual patients any Anthem Blue Cross or other health plan material in which they are told to join Anthem Blue Cross or another plan.

All information that prospective members receive about our health care plan comes from the state or from marketing activities approved by the California DHCS. The state must approve any marketing materials we create.

Providers may distribute information about our health care plan after receiving a specific member request for more information on our benefits and services.

Note: As a network provider, you may not provide prospective members with an *Enrollment Form*; you may only assist Anthem Blue Cross members (who are patients) in completing the *Enrollment Form*.

MARKETING POLICIES

Anthem Blue Cross providers are prohibited from making marketing presentations and advising or recommending to an eligible individual that he or she select membership in a particular plan.

DHCS marketing practice policies prohibit network providers from making the following false or misleading claims:

- That the PCP's office staff are employees or representatives of the state, county or federal government
- That Anthem Blue Cross is recommended or endorsed by any state or county agency or any other organization
- That the state or county recommends that a prospective member enroll with a specific health care plan
- That a prospective member or medical recipient will lose benefits under the Medi-Cal program or other welfare benefits if the prospective member does not enroll with a specific health care plan

These policies also prohibit network providers from taking the following actions:

- Making marketing presentations or allowing Anthem Blue Cross representatives to make marketing presentations to prospective members.
- Offering or giving away any form of compensation, reward or loan to a prospective member to induce or procure member enrollment in a specific health care plan.
- Engaging in direct marketing to members that is designed to increase enrollment in a particular health care plan. The prohibition should not constrain providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.
- Using any list of members obtained originally for enrollment purposes from confidential state or county data sources or from the data sources of other contractors.
- Employing marketing practices that discriminate against potential members based on marital status, age, religion, sex, gender identity, national origin, language, sexual orientation, ancestry, pre-existing psychiatric or medical conditions (such as pregnancy, disability or acquired immune deficiency syndrome), other than those specifically excluded from coverage under our contract.
- Reproducing or signing an enrollment application for the member.
- Displaying materials only from the provider's contracted managed health care organizations and excluding others.
- Engaging in any marketing activity on behalf of Anthem Blue Cross on state or county

premises or at event locations such as health fairs and festivals, athletic events, recreational activities and plan-sponsored events.

Providers are permitted to:

- Distribute copies of applications to potential members.
- Assist members in finding out what programs they qualify for and then direct them to call appropriate resources for more information.
- File a complaint with Anthem Blue Cross if a provider or member objects to any form of marketing, either by other providers or by Anthem Blue Cross representatives. (Please refer to the **Grievances and Appeals** chapter of this manual for more information)

Note: Providers are required to obtain approvals prior to using patient-focused and Anthem Blue Cross-branded marketing materials created by your office. Before distributing materials to your Medi-Cal patients, submit your materials to Anthem Blue Cross through your local Community Relations Representative. We will review and seek approval from the following agencies as appropriate:

- L.A. Care Health Plan
- Department of Health Care Services (DHCS)
- Department of Managed Health Care (DMHC)
- Managed Risk Medical Insurance Board (MRMIB)
- Other stakeholders as required

HIPAA PRIVACY, PHI, SECURITY

The Anthem Health Insurance Portability and Accountability Act of 1996 (HIPAA) **Web Privacy Statement** and additional information about privacy and security policies and procedures can be found on the *Provider Resources* page of our website at:

https://www.anthem.com/wps/portal/abc/ath/bnfooter?content_path=shared/noapplication/f0/s0/t0/pw_a103877.htm&label=Privacy%20Statement

Anthem Blue Cross uses a **secure email** encryption tool to ensure that member's **protected health information** (PHI) is kept private and secure and to help prevent identity theft. Secure email encrypts emails and attachments that it identifies as potentially having PHI. Providers can also use secure email to send encrypted email to Anthem Blue Cross when they respond to an Anthem Blue Cross-encrypted email.

Anthem Blue Cross expects that member PHI and PII is assiduously guarded and under strict security in your offices. Security for hard copy records and files must adhere to stringent confidentiality standards that meet or exceed the HIPAA regulations and California statutes related to information security. As well, unauthorized parties must not be allowed to view Anthem Blue Cross members' PHI or PII.

When you travel from the Anthem Blue Cross website to another website, whether through links provided by Anthem Blue Cross or otherwise, you will be subject to the privacy policies (or lack thereof) of the other sites. We caution you to determine the privacy policy of such sites before providing any personal information.

MISROUTED PROTECTED HEALTH INFORMATION

Providers and facilities are required to review all member information received from Anthem Blue Cross to ensure no misrouted PHI is included. Misrouted PHI includes information about members that a provider or facility is not treating. PHI can be misrouted to providers and facilities by mail, fax, email or electronic remittance advice.

Providers and facilities are required to destroy immediately 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, please contact the appropriate Customer Care Center located in **Chapter 2: Quick Reference**.

FRAUD, WASTE AND ABUSE

☎ Anthem Blue Cross Fraud, Waste and Abuse Hotline: **1-888-231-5044**

UNDERSTANDING FRAUD, WASTE AND ABUSE

We are committed to protecting the integrity of our health care program and the efficiency of our operations by preventing, detecting and investigating fraud, waste and abuse.

Combating fraud, waste and abuse begins with knowledge and awareness.

- **Fraud:** Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it or any other person. The attempt itself is fraud regardless of whether or not it is successful.
- **Waste:** Generally defined as activities involving careless, poor or inefficient billing, or treatment methods causing unnecessary expenses and/or mismanagement of resources.
- **Abuse:** Any practice inconsistent with sound fiscal, business or medical practices that results in an unnecessary cost to the Medicaid program including administrative costs from acts that adversely affect providers or members.

It should be noted that under federal law (i.e., the False Claims Act (FCA), Title 31 U.S.C. 3729 et seq.), anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for up to three times the damages or loss to the government plus civil penalties of $5,500 to $11,000 per false claim.

EXAMPLES OF PROVIDER FRAUD, WASTE AND ABUSE

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling: when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding: when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

EXAMPLES OF MEMBER FRAUD, WASTE AND ABUSE

The following are examples of member fraud, waste and abuse:

- Forging, altering or selling prescriptions
- Letting someone else use the member's Medi-Cal identification card
- Obtaining controlled substances from multiple providers
- Relocating to out-of-service plan area
- Using someone else's Medi-Cal identification card
- Violating the pain management contract

Pain management contract: A written agreement between a provider and member that the member will not misrepresent his or her need for medication. If the contract is violated, the provider has the right to drop the member from his or her practice.

REPORTING PROVIDER OR RECIPIENT FRAUD, WASTE AND ABUSE

If you suspect a provider (e.g., provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or an Anthem Blue Cross member has committed fraud, waste or abuse, **you have the right to report it**.

The name of the person reporting the incident and his or her callback number will be kept in confidence by investigators to the extent possible by law.

When reporting possible fraud, waste or abuse involving a **provider** (a doctor, dentist, counselor, medical supply company, etc.), include:

- Name, address and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility if you have it
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

When reporting possible fraud, waste or abuse involving a **member** include:

- The member's name
- The member's date of birth, Social Security number or case number if you have it
- The city where the member resides
- Specific details describing the fraud, waste or abuse

ANONYMOUS REPORTING OF SUSPECTED FRAUD, WASTE AND ABUSE

Any incident of fraud, waste or abuse may be reported to us anonymously; however, our ability to fully investigate an anonymously reported matter may be handicapped. As a result, we encourage you to provide as much detailed information as possible.

INVESTIGATION PROCESS

We investigate all reports of fraud, waste and abuse. Allegations and the investigative findings are reported to the California Department of Health Care Services (DHCS), regulatory and law enforcement agencies. In addition to reporting, we take corrective action such as:

- **Written warning and/or education**: We send certified letters to the provider or member that document the issues and the need for improvement or changes in billing activities or services rendered. Letters may include information of an educational nature, requests for recoveries or advisories denoting further action.
- **Medical record review**: We may review medical records to substantiate or refute allegations or validate claims submissions.
- **Special claims review**: A special claims review process places payment or electronic system edits on file to prevent automatic claim payment; this requires a certified medical reviewer evaluation.
- **Prepayment review**: Through a variety of means, certain providers or certain claims submitted by providers may come to The Anthem Blue Cross attention for behavior that might be identified as unusual or for coding or billing or claims activity which indicates the provider is an outlier with respect to his/her/its peers. For example, Anthem Blue Cross uses computer software tools designed to identify providers whose billing practices indicate conduct that is unusual or outside the norm of the provider's peers. Once a claim or a provider

is identified as an outlier, further investigation is conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for an unusual claim, coding or billing practice. If the investigation results in a determination that the provider's actions may involve fraud, waste or abuse, the provider is notified and given an opportunity to respond.

- **Recoveries**: We recover overpayments directly from the provider. Failure of the provider to return the supported overpayment may be reflected in reduced payment of future claims, or other administrative steps, to include possible termination from our network for participating providers, or further legal action.

FALSE CLAIMS ACT, FALSE STATEMENTS ACT, STARK LAW

We are committed to complying with all applicable federal and state laws including the federal FCA.

The FCA is a federal law that allows the government to recover money stolen through fraud by government contractors. Under the FCA, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages or loss to the government plus civil penalties of $5,500 to $11,000 per false claim.

The FCA also contains **qui tam** or whistleblower provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under qui tam provisions in the FCA and may be entitled to a percentage of the funds recovered by the government.

The False Statements Accountability Act prohibits anyone from making false statements or representations (written or oral) or withholding material information relating to a government contract and other matters under the jurisdiction of the federal government.

The Stark Law is an anti-referral statute that is directed specifically at physicians and prohibits them from making referrals for designated health services to an entity with which they or an immediate family member have a financial relationship. The definitions of *referral*, *designated health service*, *entity* and *financial relationship* are all quite broad.

All providers are advised to seek their own counsel to ensure no referral is made in violation of the Stark Law.

DELEGATION OVERSIGHT

The Anthem Blue Cross Delegation program's intent is to assure quality of care and service from contracted entities with delegated functions prior to delegation of any function and to assure compliance with all the federal, state, accreditation and organizational requirements (CMS, DMHC, NCQA, related to the delegated function.

The Delegation Program describes the plan's process for performing an objective and systematic review of the delegated functions in a consistent manner for all contracted networks or entities with a delegated function(s).

Anthem Blue Cross may delegate to a qualified provider group/entity the authority to perform selected medical management and administrative functions on its behalf. The qualified contracted provider group/entity is expected to perform such functions in a manner that is consistent with all Anthem Blue Cross standards, state and federal laws, rules, regulations and accreditation organization standards.

The qualified contracted provider group/entity is expected to comply with all requirements of network adequacy standards established in DHCS' All Plan Letter for Network Certification Requirements (Attachment A: Network Adequacy Standards). DHCS established requirements to evaluate the ability to provide medically necessary services needed for anticipated membership and utilization. The geographic requirements are

provided for distance and time from a member's residence to a contracted provider for primary care, specialty care, obstetrics/gynecology primary care, obstetrics/gynecology specialty care, hospitals, pharmacy, and mental health (non-psychiatry) outpatient services.

Additionally, the qualified contracted provider group/entity is expected to meet or exceed the required full time equivalent (FTE) provider-to-member ratio for PCPs of one primary care provider to every 2,000 members and a total network physician ratio of one FTE physician to every 1,200 members.

Anthem Blue Cross shall be responsible and liable for all administrative and operational functions of the plan described in The Anthem Blue Cross contract with the DHCS. The delegated group/entity is additionally expected and required to comply with all the requirements of the plan's DHCS contract.

At all times the plan retains the accountability and overall responsibility as well as the right to monitor and rescind the delegation function.

PROGRAM PHASES

The Anthem Blue Cross Delegation Program is divided into three phases as follows:

- Phase 1: preassessment
  - Phase 1a: preassessment documents
  - Phase 1b: preassessment review
- Phase 2: oversight and monitoring
  - Phase 2a: annual audit
  - Phase 2b: ongoing monitoring and oversight
- Phase 3: de-delegation

PROVIDER GROUP FINANCIAL OVERSIGHT

In accordance with The Anthem Blue Cross HMO Finance Policies and Procedures, the Medical Services Agreement and the California Solvency Regulations, capitated provider organizations are required to submit to Anthem Blue Cross their quarterly and annual audited financial statements pursuant to GAAP within the same time frame as mandated under Sec 1300.75.4 of Title 28 of the California Code of Regulations.

Anthem Blue Cross reviews financial data trends using The Anthem Blue Cross financial viability standards noting in particular any material changes in financial condition and unusual balances. Also, Anthem Blue Cross requires that soft copies of the provider organization's DMHC formatted quarterly and annual financial survey reports must also be provided to Anthem Blue Cross.

The depth of the analysis is based on the level of financial risk of the provider organization as determined pursuant to The Anthem Blue Cross Financial Oversight Policies and Procedures submitted and acknowledged by DMHC. In the event the provider organization does not meet any of the solvency regulations and The Anthem Blue Cross financial viability standards, the provider organization shall within 30 days upon request by Anthem Blue Cross provide a Standby Letter of Credit (SL/C) as a security reserve in an amount acceptable to Anthem Blue Cross to mitigate risk.

The Anthem Blue Cross minimum financial viability standards include the following:

1. Cash ratio of at least 90% (cash and/or equivalents plus marketable securities divided by total current liabilities)
2. Total stockholders' capital must equal to at least 6% of total revenue or 8% of total medical expenses, whichever is higher
3. Maintain a working capital ratio of at least 1.5:1
4. Maintain a debt to equity ratio of not more than 200%
5. Provision for incurred but not reported (IBNR) claims liability of at least two months of average annual claims expenses or based on the actuarial estimate approved per California regulation
6. Days cash on hand (DCOH) must at least be 60 days

Anthem Blue Cross reserves the right to amend the financial viability standards as indicated above. Hence, upon its discretion Anthem Blue Cross shall add to, delete from and otherwise modify any part of the P&P at any time.

HOSPITAL FINANCIAL REVIEW

Concurrent with The Anthem Blue Cross policy to mitigate the risk with capitated provider organizations, a set of hospital financial viability standards are similarly used as analytical guideposts in the evaluation of the capitated hospital's financial capacity as follows:

1. Minimum working capital ratio of 1.10:1
2. Minimum tangible net equity of $5 million (total assets less total liabilities less intangibles)
3. Hospital cash ratio of at least 0.9 (cash and equivalents plus marketable investments, net patient receivables and board designated funds divided by total current liabilities)
4. Days receivable equivalent to 70 days or less
5. Days cash on hand (DCOH) of at least 50 days
6. Positive operating margin

Capitated hospitals are required to provide Anthem Blue Cross with quarterly and annual financial statements based on the same time frames applicable to capitated provider organizations. The timely review of hospital financials would alert Anthem Blue Cross to those experiencing financial difficulties or have emerging financial issues that could adversely impact their financial capacity to fulfill their contractual responsibilities.

Please note that at the front-end or pre-contract stage, Anthem Blue Cross may require the applicant hospital to submit a Standby Letter of Credit (SL/C) amounting to a minimum of $300,000 or as may be determined by Anthem Blue Cross Finance in order to mitigate the inherent financial risk. Unlike the capitated provider organization, hospitals are not subject to California solvency regulations.

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