

Provider Manual

Kentucky Medicaid



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Provider Manual Table of Contents

- Chapter 1: Introduction..... 6**
 - 1.1 About Anthem 6
 - 1.2 Quick Reference Contact Information..... 6
 - 1.3 Important Contact Information 7
 - 1.4 Updates and Changes 9
- Chapter 2: Provider Types, Access and Availability 10**
 - 2.1 Provider Responsibilities 10
 - 2.2 Responsibilities of the Primary Care Provider (PCP) 13
 - 2.3 Who Can Be a Primary Care Provider? 15
 - 2.4 Primary Care Provider Onsite Availability 16
 - 2.5 Primary Care Provider Access and Availability 16
 - 2.6 Specialty Care Providers 17
 - 2.7 Role and Responsibilities of Specialty Care Providers..... 18
 - 2.8 Specialty Care Providers: Access and Availability..... 18
 - 2.9 Out-of-Network Providers 19
- Chapter 3: Provider Procedures, Tools and Support 20**
 - 3.1 Changes in Provider/Practice Information 20
 - 3.2 Material Change Notification 20
 - 3.3 Clinical Practice Guidelines..... 20
 - 3.4 Value-Based Programs (VBP) and Provider Collaboration 21
 - 3.5 Covering Providers/Locum Tenens..... 21
 - 3.6 Culturally and Linguistically Appropriate Services 22
 - 3.7 Fraud, Waste and Abuse..... 23
 - 3.8 Health Insurance Portability and Accountability Act..... 27
 - 3.9 Lab Requirements: Clinical Laboratory Improvement Amendments..... 28
 - 3.10 Marketing: Prohibited Provider Activities 30
 - 3.11 Records Standards: Member Medical Records 30
 - 3.12 Records Standards: Patient Visit Data 33
 - 3.13 Rights and Responsibilities of Anthem Members 35
- Chapter 4: Tools To Help Manage Anthem Members 39**
 - 4.1 Verifying Member Eligibility 39
 - 4.2 Member Copay Requirements 40
 - 4.3 Member Identification Cards..... 40

4.4 Automatic Assignment of Primary Care Providers	40
4.5 Missed Appointments.....	41
4.6 Nonadherent Members	42
4.7 Second Opinions	42
4.8 Member Grievances	42
4.9 Lock-In Program.....	44
Chapter 5: How Anthem Supports Its Members	45
5.1 Anthem as the Member Health Home	45
5.2 Care on Call.....	45
5.3 Advance Directives	46
5.4 Case Management Services.....	46
5.5 Condition Care	48
5.6 Enrollment	50
5.7 Language and Translation Services.....	50
5.8 Provider Directories.....	51
5.9 Welcome Call.....	51
Chapter 6: Covered Services for Members.....	52
6.1 Anthem Program Information	52
6.2 Services Covered Under the State Plan or Fee-for-Service Medicaid	52
6.3 Services Covered Under Anthem.....	52
6.4 Anthem Special Services	54
6.5 Blood Lead Screenings.....	57
6.6 Immunizations	57
6.7 Medically Necessary Services	58
6.8 Pharmacy Services	59
Chapter 7: Behavioral Health Integrated Services.....	62
7.1 Overview of Anthem’s Behavioral Health Program.....	62
7.2 Program Goals	62
7.3 Program Objectives	62
7.4 Treatment Guidelines	63
7.5 General Provider Information	65
7.6 Screening, Brief Intervention and Referral to Treatment (SBIRT)	66
7.7 Member Records and Treatment Planning	66
7.8 Community Provider Requirements	68
7.9 Psychotropic Medications	69

7.10 Utilization Management Decision Making	69
Chapter 8: Precertification/Prior Notification.....	76
8.1 Confidentiality of Information during the Process	76
8.2 Coverage Guidelines	76
8.3 Skilled Nursing Facility	78
8.4 Emergent Admissions	78
8.5 Emergency Services	79
8.6 Inpatient Admissions	79
8.7 Inpatient Reviews	80
8.8 Discharge Planning	81
8.9 Retrospective Review	81
8.10 Nonemergent Outpatient and Ancillary Services	82
8.11 Peer-to-Peer Discussion	82
8.12 Prenatal Ultrasounds	83
8.13 Urgent Care/After-hours Care	84
8.14 Members with Special Needs	84
Chapter 9: Quality Management	86
9.1 Quality Management Program	86
9.2 Quality of Care and Preventable Adverse Events	86
9.3 Quality Management Committee.....	87
9.4 Medical Policies and Clinical UM Guidelines	88
9.5 Medical Advisory Committee	89
9.6 EPSDT Provider Toolkit	90
9.7 Credentialing Scope.....	91
9.8 Credentials Committee.....	92
9.9 Nondiscrimination Policy.....	94
9.10 Initial Credentialing	94
9.11 Recredentialing.....	95
9.12 Ongoing Sanction Monitoring	96
9.13 Appeals Process	96
9.14 Reporting Requirements	97
9.15 Anthem Credentialing Program Standards.....	97
9.16 HDO Eligibility Criteria	102
Chapter 10: Provider Grievance and Payment Dispute Procedures	105
10.1 Provider Grievance Procedures	105

10.2 Provider Appeals.....	106
10.3 State Hearing Process.....	112
10.4 Continuation of Benefits during Appeals or State Fair Hearings.....	114
10.5 Payment Adjustment.....	114
Chapter 11: Claim Submission Encounters Procedures	115
11.1 Claims Submission	115
11.2 Electronic Submissions	115
11.3 Web-based Claims Submissions	117
11.4 Paper Claim Submission	117
11.5 International Classification of Diseases, 10th Revision (ICD-10) Description	117
11.6 Claims Adjudication	118
11.7 Timely Filing.....	118
11.8 Clean Claims Payments.....	118
11.9 Claims Status	120
11.10 Coordination of Benefits, Third-party Liability and Blue Card Association	120
11.11 Reimbursement Policies	120
11.12 Billing Members.....	130
11.13 Client Acknowledgment Statement.....	131
11.14 Garnishment	131
Appendix A: Forms.....	132

Chapter 1: Introduction

1.1 About Anthem

As a leader in managed healthcare services for the public sector, Anthem helps low-income families, children and pregnant women, including the Affordable Care Act (ACA) expansion population, get the healthcare needed.

Anthem helps coordinate physical and behavioral health care, and offer education and condition care programs.

Anthem strives to:

- Improve access to preventive primary care services
- Ensure selection of a primary care provider who will serve as provider, care manager and coordinator for all basic medical services
- Improve health status outcomes for members
- Educate members about member benefits, responsibilities and appropriate use of care
- Utilize community-based enterprises and community outreach
- Integrate physical and behavioral health care

Anthem encourages:

- Stable relationships between Anthem's providers and members
- Appropriate use of specialists and emergency rooms
- Member and provider satisfaction

In a world of escalating healthcare costs, Anthem works to educate members about the appropriate use of Anthem's managed care system and engage them in all aspects of member healthcare.

1.2 Quick Reference Contact Information

1.2.1 Provider Website

Anthem's provider website, providers.anthem.com/ky, offers a full complement of online tools, including:

- Downloadable forms
- Detailed eligibility look-up tool
- Comprehensive, downloadable member panel lists
- Easier submission of authorization requests
- Access to drug coverage information
- Provider Learning Hub under Availability Access on home page

1.2.2 Anthem Office Address

Anthem
13550 Triton Park Blvd., Third Floor
Louisville, KY 40223

1.3 Important Contact Information

1.3.1 Important Phone and Fax Numbers

Provider Services: <ul style="list-style-type: none"> • Interpreter/Translation Services • Claim Status • Member Eligibility 	855-661-2028 Fax: 800-964-3627	Monday through Friday 8 a.m. to 6 p.m. ET 7 a.m. to 5 p.m. CT <i>Interactive Voice Response (IVR) System available 24 hours a day, 7 days a week</i>
Member Services: <ul style="list-style-type: none"> • Interpreter/Translation Services 	855-690-7784 (TTY 711)	Monday through Friday 7 a.m. to 7 p.m. ET <i>Interactive Voice Response (IVR) System available 24 hours a day, 7 days a week</i>
Health Care Networks:	800-205-5870	Monday through Friday 8 a.m. to 5 p.m. ET
Behavioral Health Crisis Line:	855-690-7784	Monday through Friday 7 a.m. to 7 p.m. ET
Care on Call:	866-894-2544	Live agents available 24 hours a day, 7 days a week
Case Management:	855-661-2028 (Providers) 855-690-7784 (Members)	8 a.m. to 5 p.m. ET <i>Confidential voicemail is available 24 hours a day, 7 days a week</i>
Anthem Utilization Management: <ul style="list-style-type: none"> • Precertification • Utilization/Medical Management 	855-661-2028 Fax: 800-964-3627	Available 24 hours a day, 7 days a week
Condition Care (CNDC):	888-830-4300	Monday through Friday 8:30 a.m. to 5:30 p.m. ET
MedImpact Clinical Call Center:	844-336-2676 Fax: 858-357-2612 (Retail Pharmacy)	Available 7 days a week 8 a.m. to 7 p.m. ET
Anthem Clinical Call Center:	855-661-2028 Fax: 844-487-9289	Available 7 days a week 7 a.m. to 7 p.m. ET
Electronic Data Interchange <ul style="list-style-type: none"> • <i>Professional ID: 00660</i> • <i>Institutional ID: 00160</i> 	800-282-4548 (Avality Client Services)	Monday through Friday 8:00 a.m. to 8:00 p.m. ET

1.3.2 Other Key Service Providers

EyeQuest	844-870-3978 eye-quest.com	Monday through Friday 8 a.m. to 6 p.m. ET
MedImpact Pharmacy Help Desk	800-210-7628	Available 24 hours a day, 7 days a week
DentaQuest (dental services):	800-508-6787 DentaQuest.com/Kentucky	Monday through Friday 8 a.m. to 6 p.m. ET
Carelon Behavioral Health, Inc. National Provider Services Line	800-397-1630	Monday through Friday 8 a.m. to 8 p.m. ET
EPSDT (well-child care)	502-619-6800 x 26720	

1.3.3 Claims Information

Standard timely filing is within 365 calendar days from the date of service, unless otherwise specified in the provider contract.

- **Electronic Data Interchange (Availity):**

File single claim submission online with Availity Essentials at [Availity.com](https://www.availity.com).

Anthem allows all EDI Vendors submissions via Availity.

Claim Payer ID: Professional ID is 00660

Institutional ID is 00160.

You can check the status of a claim anytime by logging in to Availity Essentials at [Availity.com](https://www.availity.com) and selecting Claims & Payments > Claim Status or through Anthem's IVR system.

Submit simple batch eligibility and benefit and claim status inquiries for multiple patients with multiple plans and receive a consolidated response in a consistent format using your EDI vendor via Availity.

- **Paper:** Mail paper claims to:

Kentucky Claims

Anthem

P.O. Box 61010

Virginia Beach, VA 23466-1010

1.3.4 Provider Grievances

Provider grievances may be filed at any time using the form found at providers.anthem.com/ky

Providers should submit grievances:

- **By Fax: 855-384-4872**

- **By Paper:**

Anthem

Health Care Networks

13550 Triton Park Blvd., Third Floor

Louisville, KY 40223

- **By Phone:**

Health Care Networks: **800-205-5870**

1.3.5 Precertification/Notification

Anthem has clinical staff available 24 hours a day, 7 days a week, including federal holidays, to accept precertification requests and utilization management (UM) issues.

Submit precertification requests:

- **Online through Availity Essentials: [Availity.com](https://www.availity.com)**

- **By Fax: 800-964-3627**

- **By Phone: 855-661-2028**

Please provide:

- Member name and Medicaid ID

- Member's date of birth (DOB)

- Name, telephone number, fax number and NPI of the ordering provider

- Name, telephone number, fax number and NPI of the servicing provider/facility
- Number of visits/services
- Date of service (DOS)
- Diagnosis with ICD-10 code
- Name of elective procedure with CPT04 or HCPCS codes
- Medical information to support the request
- History and Physical
- Past and current treatment plans
- Response to treatment plans
- Medications, including frequency and dosage

For the most up-to-date precertification/notification requirements, go to providers.anthem.com/ky.

1.4 Updates and Changes

This provider manual, as part of your provider agreement and related addendums, may be updated at any time and is subject to change.

The most updated version is available online at providers.anthem.com/ky.

To request a free, printed copy of this manual, call Provider Services at **855-661-2028**.

If there is an inconsistency between information contained in this manual and the agreement between you or your facility and Anthem, the agreement governs. In the event of a material change to the information contained in this manual, we will make all reasonable efforts to notify you through web-posted newsletters, provider bulletins and other communications. In such cases, the most recently published information supersedes all previous information and is considered the current directive.

This manual is not intended to be a complete statement of all policies and procedures. We may publish other policies and procedures not included in this manual on our website or in specially targeted communications, including but not limited to bulletins and newsletters.

Chapter 2: Provider Types, Access and Availability

2.1 Provider Responsibilities

Providers are responsible for:

- Providing primary care
- Providing preventive care, recommending or arranging for all necessary preventive care, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Providing the level of care and range of services necessary to meet the medical needs of members, including those with special needs and chronic conditions
- Coordinating and monitoring recommendations to specialist care
- Providing screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems or disorders
- Coordinating and monitoring recommendations for additional care to specialized behavioral health providers in accordance with state requirements
- Referring patients to subspecialists and subspecialty groups and hospitals for consultation and diagnostics according to evidence-based criteria for such recommendations for additional care as it is available
- Authorizing hospital services
- Maintaining the continuity of care
- Assuring all medically necessary services are made available in a timely manner
- Providing services ethically and legally and in a culturally competent manner
- Monitoring and following up on care provided by other medical service providers for diagnosis and treatment
- Assure confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185 and complying with mode of communication (telephone, email, letter, etc.) as requested by the minor to maintain confidentiality
- Maintaining a complete and accurate medical record of all services rendered by the provider and other providers by documenting all care rendered
- Communicating with members about treatment options available to them, including medication treatment options regardless of benefit coverage limitations
- Providing hours of operation for members that are no less than the hours of operation offered to any other patient
- Arranging for coverage of services to assigned members 24 hours a day, 7 days a week in person or by an on-call practitioner
- Offering evening and Saturday appointments for members (strongly encouraged for all PCPs)
- Continuing care in progress during and after termination of the provider contract for up to 60 days (up to 90 days if the member is receiving inpatient services) until a continuity of care plan is in place to transition the member to another provider or through postpartum care for pregnant members in accordance with applicable state laws and regulations
- Coordination of members with Kentucky regional support networks and substance abuse disorder services programs in support of member recovery
- Discussing advance directives with all members as appropriate

- Anthem will not require Providers to perform any treatment or procedure that is contrary to the Provider’s conscience, religious beliefs, or ethical principles in accordance with 42 C.F.R.438.102.
- Providing covered services in the most cost-effective, clinically appropriate setting and manner; in addition, provider must utilize participating providers, and when medically necessary or appropriate, refer and transfer members to participating providers for all covered services, including but not limited to specialty, laboratory, ancillary and supplemental services

2.1.1 Access and Availability Requirements

As part of Anthem’s commitment to providing the best quality provider networks for the plan’s members, Anthem conducts quarterly telephonic surveys to verify provider appointment availability, provider hours of operation and after-hours access. Providers will be asked to participate in this survey each year.

Anthem will routinely monitor providers’ adherence to access-to-care standards and appointment wait times. The providers are expected to meet federal and state accessibility standards and those standards defined in the Americans with Disabilities Act of 1990. All service locations must meet the requirements of the Americans with Disabilities Act, Commonwealth and local requirements pertaining to adequate space, supplies, sanitation and fire and safety procedures applicable to healthcare facilities. Healthcare services provided through Anthem must be accessible to all members. This includes ensuring that individuals with disabilities have physical access to provider offices (Physical accessibility is not limited to entry to a provider site, but also includes access to services within the site, for example, exam tables and medical equipment). Anthem and its providers will cooperate with the Cabinet for Health and Family Services’ independent ombudsman program, including providing immediate access to a member’s records when written member consent is provided.

2.1.2 Discriminatory Practices

Providers may not use discriminatory practices such as:

- Showing preference to other insured or private-pay patients
- Maintaining separate waiting rooms
- Maintaining appointment days
- Denying or not providing to a member any covered service or availability of a facility
- Condition the provision of care or otherwise discriminate against Anthem members based on whether the members have executed advance directives
- Providing to a member any covered service that is different or is provided in a different manner or at a different time from that provided to other members, other public or private patients or the public at large

2.1.3 Submitting Provider Demographic Data Requests and Roster Submissions through Roster Automation

Use the Provider Data Management (PDM) application on Availity Essentials to verify and initiate care provider demographic change requests for all professional and facility care providers*. **Going forward, the PDM application is now the preferred intake tool for care providers to submit demographic change requests, including submitting roster uploads.** If preferred, Providers may continue to utilize the Provider Enrollment application in Availity Essentials to submit requests to add new practitioners under existing groups for available provider types.

Within the PDM application, Providers have the choice and flexibility to request data updates via the

standard PDM experience or by submitting a spreadsheet via a roster upload.

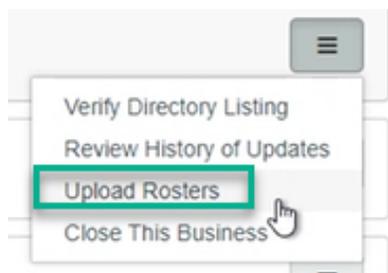
Roster Automation is our new technology solution designed to streamline and automate provider data additions, changes, and terminations that are submitted using a standardized Microsoft Excel document. Any provider, whether an individual provider/practitioner, group, or facility, can use Roster Automation today:**

The resources for this process are listed below and available on our website. Visit providers.anthem.com/ky, then under **For Providers**, select **Forms and Guides**. The **Roster Automation Rules of Engagement** and **Roster Automation Standard Template** appear under the Digital Tools category.

- **Roster Automation Rules of Engagement:** Is a reference document, available to ensure error-free submissions, driving accurate and more timely updates through automation.
- **Roster Automation Standard Template:** Use this template to submit your information. More detailed instructions on formatting and submission requirements can also be found on the first tab of the Roster Automation Standard Template (*User Reference Guide*).
- Upload your completed roster via the Availity PDM application.

Accessing PDM Application

Log onto Availity.com and select **My Providers > Provider Data Management** to begin the attestation process. If submitting a roster, find the TIN/business name for which you want to verify and update information. Before you select the TIN/business name, select the three-bar menu option on the right side of the window, and select **Upload Rosters** (see screen shot below) and follow the prompts.



Availity Administrators will automatically be granted access to PDM. Additional staff may be given access to **Provider Data Management** by an administrator. To find your administrator, go to **My Account Dashboard > My Account > Organization(s) > Administrator Information**.

* Exclusions:

- Behavioral Health providers contracted with Carelon Behavioral Health who will continue to follow the process for demographic requests and/or roster submissions, as outlined by Carelon Behavioral Health.
- Any specific state mandates or requirements for provider demographic updates

** If any roster data updates require credentialing, your submission will be routed appropriately for further action.

2.2 Responsibilities of the Primary Care Provider (PCP)

2.2.1 Communicate with Members

- Treat all members with respect and dignity.
- Provide members with appropriate privacy.
- Make provisions to communicate in the language or fashion primarily used by the member. The provider should contact Provider Services for help with oral translation/ interpreter services if needed.
- Freely communicate with members about treatment regardless of benefit coverage limitations.
- Provide complete information concerning diagnoses, evaluations, treatments and prognoses and give members the opportunity to participate in decisions involving the member's healthcare.
- Advise members about the member's health status, medical care and treatment options regardless of whether benefits for such care are provided under the program.
- Advise members on treatments which may be self-administered.
- Contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings.

2.2.2 Member Primary Care Provider Change

In the event of a member primary care provider change, the initial PCP must continue to serve the member until the new PCP assignment becomes effective, barring ethical or legal issues. The member has the right to appeal such a transfer via Anthem's formal appeal process.

PCPs with Closed Patient Panels:

- It is the PCP's responsibility to review the monthly managed care membership report. If a member appears as an addition and is not an existing patient, notify an Anthem provider relationship management representatives immediately. The notification should contain the member ID number and name. Anthem will notify the member and ask him or her to select a new PCP.
- If notification from the PCP does not occur within 30 days, the PCP will be expected to provide healthcare until the member is removed from the provider's patient panel.
- Anthem will send confirmation to the provider that the member has been removed and the effective date.

PCP Panel Disenrollment Requirements:

- PCPs shall have the right to request a member's disenrollment from his/her practice and be reassigned to a new PCP in the following circumstances: incompatibility of the PCP/patient relationship or inability to meet the medical needs of the member or if a member has not utilized a service within one year of assignment to the PCP's practice and the PCP has documented unsuccessful contact attempts by mail and phone on at least six separate occasions during the year.
- PCPs shall not have the right to request a member's disenrollment from the provider's practice for the following: a change in the member's health status or need for treatment; a member's utilization of medical services; a member's diminished mental capacity; or, disruptive behavior that results from the member's special healthcare needs unless the behavior impairs the ability of the PCP to furnish services to the member or others. Transfer requests shall not be based on

race, color, national origin, handicap, age or gender. Anthem shall have authority to approve all transfers.

Process to Make a Primary Care Provider Change:

- The provider shall submit the change for request in writing to Provider Services.
- The member may request a PCP change in writing, face to face or via telephone by contacting Member Services.

If the request does not meet the above stated requirements, the appropriate provider relationship management representative will contact the PCP directly to discuss.

2.2.3 Maintain Medical Records

- Treat members' disclosures and records confidentially, giving members the opportunity to approve or refuse the member's release
- Maintain the confidentiality of family planning information and records for each individual member, including those of minor patients
- Comply with all applicable federal and state laws regarding the confidentiality of patient records
- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of clinical research shall be clearly contrasted with entries regarding the provision of non-research-related care
- Share records subject to applicable confidentiality and Health Insurance Portability and Accountability Act (*HIPAA*) requirements
- Obtain/store medical records from any specialty recommendations for additional care in members' medical records
- Manage the medical and healthcare needs of members to assure all medically necessary services are made available in a timely manner
- Medical records should generally be preserved and maintained by the Provider for a minimum of five (5) years unless federal requirements mandate a longer retention period.
- Medical Records should be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete Medical Records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other healthcare professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract.
- Medical Record should be signed by the provider of service.

2.2.4 Cooperate and Communicate with Anthem

- Participate in:
 - Internal and external quality assurance
 - Utilization review
 - Continuing education
 - Other similar programs
 - Complaint and grievance procedures when notified of a member grievance
 - Medical record audits to support activities such as, but not limited to: prepayment and postpayment claim reviews, risk adjustment, and HEDIS.
- Inform Anthem if a member objects to provision of any counseling, treatments or referral services for religious reasons

- Identify children or adult members with special healthcare needs during the course of any contact or member-initiated healthcare visit and report these members to Anthem so that Anthem can help the members with additional services
- Identify members who would benefit from Anthem’s case management/condition care programs
- Comply with Anthem’s Quality Improvement program initiatives and any related policies and procedures to provide quality care in a cost-effective and reasonable manner
- Notify Anthem when changes occur within the provider organization

2.2.5 Cooperate and Communicate with Other Providers

- Monitor and follow up on care provided by other medical service providers for diagnosis and treatment, including services available under Medicaid fee-for-service
- Provide the coordination necessary for the referral of patients to specialists and for the recommendations for additional care of patients to services that may be available through Medicaid
- Provide case management services to include but not be limited to screening and assessing, developing a plan of care to address risks, medical/behavioral health needs and other responsibilities as defined in the state’s program
- Coordinate the services Anthem furnishes to the member with the services the member receives from any other managed care organization (MCO) network program during member transition
- Share with other healthcare providers serving the member the results of the provider identification and assessment of any member with special healthcare needs (as defined by the state) so those activities are not duplicated

2.2.6 Cooperate and Communicate with Other Agencies

- Maintain communication with the appropriate agencies such as:
 - Local police
 - Social services agencies
 - Poison control centers
 - Women, Infants and Children (WIC) program
 - Department of Behavioral Health, Developmental and Intellectual Disabilities (DBHDID)
- Develop and maintain an exposure control plan in compliance with Occupational Safety and Health Administration (OSHA) standards regarding blood-borne pathogens
- Establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act
- Coordinate the services Anthem furnishes to the member with the services the member receives from any other MCO during ongoing care and transitions of care

2.3 Who Can Be a Primary Care Provider?

Providers with the following specialties can apply for enrollment with Anthem as a PCP:

- Advanced practice registered nurse, including:
 - Nurse practitioner
 - Nurse midwife
 - Clinical specialist
- Doctor of osteopathy

- Family practitioner
- General practitioner
- Internist
- Pediatrician
- Physician assistant under the supervision of a physician
- Obstetrics-gynecology (OB-GYN)

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

- The member has a chronic illness.
- The member has a disabling condition.
- The member is a child with special healthcare needs.

For EPSDT screenings, any qualified provider operating within the scope of his or her practice, as defined by state law, can provide this service. For additional information regarding EPSDT provider administrations of services, please see the Anthem provider website.

2.4 Primary Care Provider Onsite Availability

PCPs are required to abide by the following standards to ensure access to care for Anthem members:

- Offer 24-hour-a-day, 7-day-a-week telephone access for members. A 24-hour telephone service may be used. The service may be answered by a designee such as a(n):
 - On-call physician
 - Nurse practitioner with physician backup
- Any calls that need to be returned must be done within a maximum of 30 minutes.
- Be available to provide medically necessary services. The provider or another provider must offer this service.
- Follow the precertification guidelines. This is a requirement for covering physicians.

Additionally, Anthem encourages PCPs to offer after-hours office care in the evenings and on Saturdays.

It is not acceptable to automatically direct the member to the emergency room when the PCP is not available, to utilize an answering machine or return after-hours calls outside of 30 minutes.

2.5 Primary Care Provider Access and Availability

The ability for Anthem to provide quality access to care depends upon the provider's availability. In-office wait time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room. PCP's are required to adhere to the following access standards:

Type of Care	Standard
Emergency	Immediately
Urgent care	Within 48 hours
Non-urgent sick care	Within 10 calendar days
Routine or preventive care	Within 30 calendar days
Transitional healthcare by a PCP...	...shall be available for clinical assessment and care planning within seven calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders, or discharge from a substance use disorder treatment program
Transitional healthcare by a home care nurse or home care registered counselor...	...shall be available within seven calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program.

**Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.

Emergency Care as defined in 42 USC 1395dd and 42 C.F.R. 438.114 is available to members 24 hours a day, seven (7) days a week. Urgent Care services will be made available within 48 hours of request. Urgent Care means care for a condition that is not likely to cause death or lasting harm but for which treatment should not wait for a normally scheduled appointment. Post Stabilization Care services are covered and reimbursed in accordance with 42 C.F.R. 422.113(c) and 438.114(e).

2.6 Specialty Care Providers

A specialty care provider is a network provider responsible for providing specialized care for members, usually upon appropriate recommendations for additional care from members' PCPs. Referrals are not required to specialty providers.

Members and providers can access a searchable online provider directory by logging into Anthem's website: providers.anthem.com/ky.

To assist PCPs in meeting the needs of children with mental health diagnoses, Anthem will provide PCPs access to consultation with child psychiatrists. For more information on how to arrange for these consultations, call the Anthem Provider Services team at **855-661-2028**.

2.6.1 Access to Women's Health Specialists

Female members may directly access women's health specialists within the Anthem network for covered routine and preventive healthcare services. Services include, but may not be limited to, maternity care, reproductive health services, gynecological care, general examination and preventive care as medically appropriate and medically appropriate follow-up visits for these services. General examinations, preventive care and medically appropriate follow-up care are limited to services related to maternity, reproductive health services, gynecological care or other health services that are particular to women, such as breast examinations. Women's healthcare services also include any appropriate healthcare service for other health problems, discovered and treated during the course of a visit to a women's healthcare practitioner for a women's healthcare service, which is within the practitioner's scope of practice. For purposes of determining a woman's right to directly access health services covered by the plan, maternity care, reproductive health and preventive services include: contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breast-feeding and pregnancy complications.

Additionally, Anthem will:

- Ensure confidentiality of all information related to women’s health services will be maintained
- Not exclude or limit access to covered women’s health services
- Not impose notification/authorizations upon women’s healthcare practitioners that are not imposed on providers offering similar types of service
- Include coverage for medical appropriate laboratory, imaging and diagnostic services, prescriptions, medical supplies ordered by a directly accessed participating women’s healthcare practitioners within the provider’s scope of practice

2.7 Role and Responsibilities of Specialty Care Providers

Specialty care providers are responsible for:

- Complying with all applicable statutory and regulatory requirements of the Medicaid program
- Accepting all members referred to the provider
- Submitting required claims information including source of recommendations for additional care
- Arranging for coverage with network providers while off duty or on vacation
- Verifying member eligibility and precertification of services at each visit
- Providing consultation summaries or appropriate periodic progress notes to the member’s PCP on a timely basis
- Notifying the member’s PCP when scheduling a hospital admission or scheduling any procedure requiring the PCP’s approval
- Adhering to the same responsibilities as the PCP
- Coordinating care with other providers for:
 - Physical and behavioral health comorbidities
 - Co-occurring behavioral health disorders

2.8 Specialty Care Providers: Access and Availability

The ability for Anthem to provide quality access to care depends upon the provider’s availability. In-office wait time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining. Specialty care providers are required to adhere to the following access standards:

Type of Care	Standard
Emergency	Immediately
Urgent care	Within 48 hours
Non-urgent sick care	Within 10 calendar days
Routine or preventive care	Within 30 calendar days
General/Routine vision	Within 30 calendar days; urgent care within 48 hours
Laboratory and radiology	Within 30 calendar days; urgent care within 48 hours

Each patient should be notified immediately if the provider is delayed for any period of time. If the appointment wait-time is anticipated to be more than 45 minutes, the patient should be offered a new appointment. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.

Emergency Care as defined in 42 USC 1395dd and 42 C.F.R. 438.114 is available to members 24 hours a day, seven (7) days a week. Urgent Care services will be made available within 48 hours of request. Urgent Care means care for a condition that is not likely to cause death or lasting harm but for which treatment should not wait for a normally scheduled appointment. Post Stabilization Care services are covered and reimbursed in accordance with 42 C.F.R. 422.113(c) and 438.114(e).

2.9 Out-of-Network Providers

Out-of-network providers must obtain prior authorization for all nonemergent services. Plan policies and procedures, including those outlining the authorization of services, are available to out-of-network providers upon request or by calling Provider Services at **855-661-2028** or by visiting providers.anthem.com/ky.

Chapter 3: Provider Procedures, Tools and Support

3.1 Changes in Provider/Practice Information

To maintain the quality of Anthem's provider data, Anthem asks that changes to the practice contact information or the information of participating providers within a practice be submitted as soon as the practice is aware of the change; preferably within 30 days prior to the effective date of the change. The Provider Maintenance Form (PMF) should be utilized to submit all changes.

To submit the PMF, please visit **anthem.com** and follow the steps below:

1. Select the **For Providers** link, then select **Provider Maintenance**.
2. Select **Kentucky** and then **Enter**.
3. Scroll down and select the **Provider Maintenance Form** link.
central.provider.anthem.com/mwpmf/entpmf/landingpage?brand=kyabcbs
4. Follow the instructions to attach any required documentation and complete the online form.
5. For any questions about completing the PMF, please call Provider Services at **855-661-2028**.

3.2 Material Change Notification

Anthem communicates with all participating providers any material changes to the existing provider contract following regulatory guidelines. If a material change is made, the provider will be provided with at least 90 days' notice the following information:

- Effective date of the change
- Description of the change to the existing contract
- Notification of providers option to accept or reject the change
- Contact information for a representative at Anthem to discuss the change

Additionally, the provider has the opportunity to request a meeting to discuss concerns about the change with Anthem representatives. If Anthem has cause to make three or more material changes to a contract in a rolling 12 month period, the participating provider may request an updated copy of the contract for informational purposes. This updated contract with changes consolidated will have no effect on the terms and conditions of the contract.

In the event the provider would like to oppose the material change to the contract, the provider should submit any objections in writing within 30 days of receiving the notification of the change. An Anthem representative will then work to come to an agreement on the change over the following 30 days. If an agreement cannot be reached between Anthem and the provider, providers will have 30 days to terminate the contract and provide notice to members to prevent any gaps in care caused by this dissolution.

3.3 Clinical Practice Guidelines

Anthem works with providers to develop clinical policies and guidelines. Each year, Anthem selects at least four evidence-based clinical practice guidelines that are relevant to Anthem's members and measure at least two important aspects of each of those four guidelines. Anthem also reviews and

revises these guidelines at least every two years. Anthem can find these Clinical Practice Guidelines on the provider website: providers.anthem.com/ky.

3.4 Value-Based Programs (VBP) and Provider Collaboration

An important part of Anthem's approach to maintaining a strong, effective provider network is meeting providers where they are with regard to capability and comfort on their path to assuming risk. The goal of our value-based payment program is to support providers' success and, over time, movement through the continuum to accept more risk and to improve healthcare quality in terms of access, outcomes, and savings.

Our VBP and provider collaboration models provide an effective framework to incent providers to collaborate on effective population health management strategies. We design our enablement strategies to train and support provider organizations in the techniques and tools for managing population health risks, enabling providers to become more willing to assume risk and more effective at producing improved outcomes for members.

Anthem's Suite of Value-Based Programs

- **Provider Quality Incentive Program (PQIP).** Implemented in 2016, PQIP (HCP-LAN category 3A) provides incentives for PCPs to undertake systemic improvements that affect both healthcare outcomes and cost trends
- **Provider Quality Incentive Program Essentials (PQIP Essentials).** Implemented in 2018, PQIP Essentials (HCP-LAN category 3A) incents smaller practices, focusing on PCPs with 250-999 attributed Members
- **Behavioral Health Quality Incentive Program (BHQIP).** Implemented in 2017, BHQIP (HCP-LAN category 2C) incents eligible BH Providers (such as Community Mental Health Centers and high-volume BH groups) to improve coordination of Members' PH and BH needs and the quality of care provided to Members with BH conditions
- **Behavioral Health Facility Incentive Program (BHFIP).** Implemented in 2018, BHFIP (HCP-LAN category 2C) offers incentives to BH inpatient facilities for improvements in indicators related to clinical quality and patient outcomes (readmission rates, follow-up rates with a BH Provider)

**Additional programming to be added in the future for other provider populations.

3.5 Covering Providers/Locum Tenens

During provider absence or unavailability, the provider must arrange for coverage for members assigned to the provider panel. The provider will be responsible for making arrangements with:

- One or more network providers to provide care for Anthem members or
- Another similarly licensed and qualified participating provider who has appropriate medical staff privileges at the same network hospital or medical group to provide care to the members in question

In addition, the covering provider will agree to the terms and conditions of the network provider agreement, including any applicable limitations on compensation, billing and participation.

A Locum Tenens provider is defined as a provider who is not a network provider and who is temporarily rendering services for a practitioner who may be on leave of absence by reason of vacation, illness, maternity leave or other personal leave.

Any Locum Tenens provider rendering services for less than six months is not required to be credentialed. A *Provider Maintenance Form (PMF)* should be completed with a notation in the comment section stating “Locum Tenens.” A noncredentialed Locum Tenens provider will not be represented in any member materials. Locum Tenens providers rendering services to central region covered individuals for six or more months are no longer considered Locum Tenens and must be credentialed if the provider practices in a specialty and/or capacity that currently require credentialing.

3.6 Culturally and Linguistically Appropriate Services

Patient panels are increasingly diverse and needs are becoming more complex. It is important for providers to have the knowledge, resources, and tools to offer culturally competent and linguistically appropriate care. Anthem wants to help, as we all work together to achieve health equity.

The U.S. Department of Health and Human Services (HHS) defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. It is a dynamic, ongoing developmental process requiring long-term commitment. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains that healthcare is defined through a cultural lens for both patients and providers. A person’s cultural affiliations can influence:

- Where and how care is accessed, how symptoms are described,
- Expectations of care and treatment options,
- Adherence to care recommendations.

Providers also bring their own cultural orientations, including the culture of medicine.

Offering culturally and linguistically appropriate care incorporates a variety of skills and knowledge, including, but not limited to, the ability to:

- Recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior.
- Develop understanding of others’ needs, values and preferred means of having those needs met
- Formulate culturally competent treatment plans.
- Understand how and when to use language support services, including formally trained interpreters and auxiliary aids and services, to support effective communication.
- Avoid use of family members, especially minors, to act as interpreters for limited English proficient patients.
- Understand and adhere to regulations to support the needs of diverse patients, such as the Americans with Disabilities Act (ADA).
- Use culturally appropriate community resources as needed to support patient needs and care.

Anthem ensures providers have access to resources to help support delivery of culturally and linguistically appropriate services. Anthem encourages providers to access and utilize **MyDiversePatients.com**

MyDiversePatients.com: The My Diverse Patients website offers resources, information, and techniques, to help provide the individualized care every patient deserves regardless of their diverse backgrounds. The site also includes learning experiences on topics related to cultural competency and disparities that offer free Continuing Medical Education (CME) credit. Current CME offerings include:

- **Caring for Children with ADHD:** Promotes understanding of and adherence to diagnosis and treatment guidelines; use of AAP's Resource Toolkit for Clinicians; awareness of and strategies for addressing disparities.
- **My Inclusive Practice - Improving Care for LGBTQIA+ Patients:** Helps providers understand the fears and anxieties LGBTQIA+ patients often feel about seeking medical care, learn key health concerns of LGBTQIA+ patients, & develop strategies for providing effective healthcare to LGBTQIA+ patients.
- **Improving the Patient Experience:** Helps providers identify opportunities and strategies to improve patient experience during a healthcare encounter.
- **Medication Adherence:** Helps providers identify contributing factors to medication adherence disparities for diverse populations & learn techniques to improve patient-centered communication to support needs of diverse patients.
- **Moving Toward Equity in Asthma Care:** Helps providers understand issues often faced by diverse patients with asthma & develop strategies for communicating to enhance patient understanding.
- **Reducing Healthcare Stereotype Threat (HCST):** Helps providers understand HCST and the implications for diverse patients as well as the benefits of reducing HCST to both providers' patients and practices, and how to do so.

Cultural Competency Training (Cultural Competency and Patient Engagement): A training resource to increase cultural and disability competency to help effectively support the health and healthcare needs of your diverse patients.

Caring for Diverse Populations Toolkit: A comprehensive resource to help providers and office staff increase effective communication by enhancing knowledge of the values, beliefs, and needs of diverse patients.

Anthem appreciates the shared commitment to ensuring Members receive culturally and linguistically appropriate services to support effective care and improved health outcomes.

3.7 Fraud, Waste and Abuse

First Line of Defense Against Fraud

We are committed to protecting the integrity of our healthcare program and the effectiveness 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. This includes any act that constitutes fraud under applicable Federal or State law.

- **Waste:** Includes overusing services, or other practices that, directly or indirectly, result in excessive costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- **Abuse:** behaviors that are inconsistent with sound financial, business and medical practices and result in unnecessary costs and payments for services that are not medically necessary or fail to meet professionally recognized standards for healthcare. This includes any member actions that result in unnecessary costs.

To help prevent fraud, waste and abuse, providers can assist by educating members. For example, spending time with members and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent member fraud is as simple as reviewing the member identification card. It is the first line of defense against possible fraud. Learn more at fighthealthcarefraud.com

To help prevent member fraud, waste and abuse:

- Educate members
- Be observant
- Spend time with members and review the individual's prescription record
- Review the member's Anthem member ID card
- Make sure the cardholder is the person named on the card
- Encourage members to protect ID cards like credit cards or cash
- Encourage them to report any lost or stolen card to us immediately

Reporting Fraud, Waste and Abuse

If you suspect a provider (for example, provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any member (a person who receives benefits) has committed fraud, waste or abuse, you have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person and their information, if supplied, who reports the incident is kept in strict confidence by the Special Investigations Unit (SIU).

You can report your concerns by:

- Visiting our fighthealthcarefraud.com education site; at the top of the page click "Report it" and complete the "Report Waste, Fraud and Abuse" form
- Calling Provider Services at 855-661-2028 if you are a network provider
- Calling Customer Service

855-661-2028

Any incident of fraud, waste or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. We appreciate your time in referring suspected fraud, but be advised that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.

Examples of Provider Fraud, Waste and Abuse (FWA):

- 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
- Overutilization
- 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

When reporting concerns 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

Examples of Member Fraud, Waste and Abuse

- Forging, altering or selling prescriptions
- Letting someone else use the member's ID (identification) card
- Relocating to out-of-service Plan area and not notifying us
- Using someone else's ID card

When reporting concerns involving a member include:

- The member's name
- The member's date of birth, Member ID, or case number if you have it
- The city where the member resides
- Specific details describing the fraud, waste or abuse

Investigation Process

Our Special Investigations Unit (SIU) reviews all reports of provider or member fraud, waste and abuse for all services. If appropriate, allegations and the investigative findings are reported to all appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste or abuse, which may include, but is not limited to:

- *Written warning and/or education:* We send certified letters to the Provider documenting the issues and the need for improvement. Letters may include education or requests for recoveries or may advise of further action.
- *Medical record review:* We review medical records in context to previously submitted claims and/or to substantiate allegations.
- *Prepayment Review:* A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.
- *Recoveries:* We recover overpayments directly from the provider. Failure of the provider to return the overpayment may result in reduced payment of future claims and/or further legal action.

If you are working with the SIU all checks and correspondence should be sent to:

Anthem

Special Investigations Unit
740 W Peachtree Street NW
Atlanta, Georgia 30308
Attn: investigator name, #case number

Paper medical records and/or claims are a different address, which is supplied in correspondence from the SIU. If you have questions, contact your investigator. An opportunity to submit claims and/or supporting medical records electronically is an option if you register for an Availity account. Contact Availity Client Services at **800-AVAILITY (282-4548)** for more information.

About Prepayment Review

One method we use to detect FWA is through prepayment Claim review. Through a variety of means, certain Providers (Facilities or Professionals), or certain Claims submitted by Providers, may come to our attention for behavior that might be identified as unusual for coding, documentation and/or billing issues, or Claims activity that indicates the Provider is an outlier compared to his/her/its peers.

Once a Claim, or a Provider, is identified as an outlier or has otherwise come to our attention for reasons mentioned above, further review may be conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the review results in a determination the Provider's action(s) may involve FWA, unless exigent circumstances exist, the Provider is notified of their placement on prepayment review and given an opportunity to respond.

When a Provider is on prepayment review, the Provider will be required to submit medical records and any other supporting documentation with each Claim so the SIU can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation in accordance with this requirement will result in a denial of the Claim under review. The Provider will be given the opportunity to request a discussion of his/her/its prepayment review status.

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

The Provider will remain subject to the prepayment review process until the health plan is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the inappropriate activity is not corrected, the Provider could face corrective measures, up to and including termination from the network at the direction of the State.

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

Acting on Investigative Findings

If, after investigation, the SIU determines a provider appears to have committed fraud, waste, or abuse the provider:

- May be presented to the credentials committee and/or peer review committee for disciplinary action, including provider termination
- Will be referred to other authorities as applicable and/or designated by the State
- The SIU will refer all suspected criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

Failure to comply with program policy or procedures, or any violation of the contract, may result in termination from our plan. If a member appears to have committed fraud, waste or abuse or has failed to correct issues, the member may be involuntarily dis-enrolled from our healthcare plan, with state approval.

3.8 Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (*HIPAA*):

- Improves the portability and continuity of health benefits
- Provides greater patient rights to access and privacy
- Ensures greater accountability in healthcare fraud
- Simplifies the administration of health insurance

Anthem is committed to safeguarding patient/member information. As a contracted provider, providers must have procedures in place to demonstrate compliance with *HIPAA* privacy regulations. Providers must also have safeguards in place to protect patient/member information such as locked cabinets clearly marked and containing only protected health information, unique employee passwords for accessing computers and active screen savers.

Member individual privacy rights include the right to:

- Receive a copy of Anthem's provider notice of privacy practices
- Request and receive a copy of his or her medical records and request those records be amended or corrected
- For members under the age of 18, assure confidentiality of services for diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse for addiction, contraception, or pregnancy or childbirth without parental notification or consent in accordance with KRS 214.185
- Get an accounting of certain disclosures of his or her Protected Health Information (PHI)
- Ask that his or her PHI not be used or shared
- Ask each provider to communicate with him or her about PHI in a certain way or location
- File a complaint with his or her provider or the Secretary of Health and Human Services if privacy rights are suspected to be violated
- Designate a personal representative to act on his or her behalf
- Authorize disclosures of PHI outside of treatment, payment or healthcare operations and cancel such authorizations

Anthem only requests the minimum member information necessary to accomplish Anthem's purpose. Likewise, Anthem should only request the minimum member information necessary for the provider's purpose. However, regulations do allow the transfer or sharing of member information to:

- Conduct business and make decisions about care

- Make an authorization determination
- Resolve a payment appeal

Requests for such information fit the *HIPAA* definition of treatment, payment or healthcare operations.

Providers should maintain fax machines used for transmitting and receiving medically sensitive information in a restricted area. When faxing information to Anthem, please:

- Verify the receiving fax number
- Notify Anthem that the provider is faxing information
- Verify that Anthem received the provider's fax

Do not use Internet email (unless encrypted) to transfer files containing member information to Anthem. Providers should mail or fax this information. Mail medical records in a sealed envelope marked **confidential** and addressed to a specific individual or department in the Anthem Company.

Anthem's voice mail system is secure and password protected. Providers should only leave messages with the minimum amount of member information necessary.

When contacting Anthem, please be prepared to verify the provider's:

- Name
- Address
- NPI number
- TIN
- Anthem provider number

3.8.1 Misrouted Protected Health Information

Providers and facilities are required to review all member information received from Anthem 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, e-mail 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 Customer Care Center: **855-661-2028**.

3.9 Lab Requirements: Clinical Laboratory Improvement Amendments

Anthem is bound by the Clinical Laboratory Improvement Amendments (CLIA) of 1988. The purpose of the CLIA program is to ensure laboratories that test specimens consistently provide accurate procedures and services. Claims that are submitted for laboratory services subject to the Clinical Laboratory Improvement Amendments of 1988 (CLIA) statute and regulations require additional information to be considered for payment.

To be considered for reimbursement of clinical laboratory services, a valid CLIA certificate identification number must be reported on a 1500 Health Insurance Claim Form (CMS-1500) or its electronic equivalent for clinical laboratory services. The CLIA certificate identification number must be submitted in one of the following manners:

Claim format and elements	CLIA number location options	Referring provider name and NPI number location options	Servicing laboratory physical location
CMS-1500 (formerly HCFA-1500)	Must be represented in field 23	Submit the referring provider name and NPI number in fields 17 and 17b, respectively.	Submit the servicing provider name, full physical address and NPI number in fields 32 and 32A, respectively, if the servicing address is not equal to the billing provider address. The servicing provider address must match the address associated with the CLIA ID entered in field 23.
HIPAA 5010 837 Professional	Must be represented in the 2300 loop, REF02 element, with qualifier of X4 in REF01	Submit the referring provider name and NPI number in the 2310A loop, NM1 segment.	Physical address of servicing provider must be represented in the 2310C loop if not equal to the billing provider address and must match the address associated with the CLIA ID submitted in the 2300 loop, REF02.

To be considered for reimbursement of reference laboratory services, the referring laboratory must be an independent clinical laboratory. Modifier 90 must be submitted to denote the referred laboratory procedure. Per the Centers for Medicare & Medicaid (CMS), an independent clinical laboratory that submits claims in paper format may not combine non-referred or self-performed and referred services on the same CMS-1500 claim form. Thus, when the referring laboratory bills for both non-referred and referred tests, it must submit two separate paper claims: one claim for non-referred tests and the other for referred tests. If submitted electronically, the reference laboratory must be represented in the 2300 or 2400 loop, REF02 element, with qualifier of F4 in REF01.

Providers who have obtained a CLIA Waiver or Provider Performed Microscopy Procedure accreditation must include the QW modifier when any CLIA waived laboratory service is reported on a CMS-1500 claim form.

Laboratory procedures must be rendered by an appropriately licensed or certified laboratory having the appropriate level of CLIA accreditation for the particular test performed. Thus, any claim that does not contain the CLIA ID, has an invalid ID, has a lab accreditation level that does not support the billed service code, does not have complete servicing provider demographic information and/or applicable reference laboratory provider demographic information, will be considered incomplete and rejected or denied.

3.10 Marketing: Prohibited Provider Activities

Federal regulations define marketing to include any communication from an MCO or provider to a Medicaid recipient that can reasonably be interpreted as intended to influence the recipient to enroll in that particular MCO, or either to not enroll in, or to dis-enroll from, another MCO.

Anthem and its subcontractors, including healthcare providers, are prohibited from engaging in the following, which are considered to be member-marketing activities:

- Distributing plans and materials or making any statement (written or verbal) that the Department for Medicaid Services (DMS) determines to be inaccurate, false, confusing, misleading or intended to defraud members or DMS; this includes statements which mislead or falsely describe covered services, membership, availability of providers, qualifications and skills of providers or assertions the recipient of the communication must enroll in a specific health plan in order to obtain or not lose benefits
- Distributing marketing materials (written or verbal) that have not been reviewed and approved in advance by DMS
- Asserting that Anthem or any other DMS participating Managed Care Organization (MCO) is endorsed by the Centers for Medicare & Medicaid Services, the federal government, the Commonwealth, or any other similar entity
- Influencing enrollment in a particular MCO, or either to not enroll in, or to dis-enroll from, another MCO.
- Influencing enrollment in conjunction with the sale or offer of any private insurance
- Assisting with enrollment or improperly influencing MCO selection
- Using the seal of the state of, logo or other identifying marks on any materials produced or issued without the prior written consent of DMS
- Use of any Anthem trademark or logo without prior express written consent from Anthem
- Distributing marketing information (written or verbal) that implies joining DMS MCO networks or a particular DMS MCO network is the only means of preserving Medicaid coverage, that DMS MCO networks or a particular DMS MCO network is the only provider of Medicaid services and the potential enrollee must enroll in the DMS MCO network or networks to obtain benefits or not lose benefits
- Sponsoring or attending any marketing or community health activities or events without notifying DMS at least 30 days in advance
- Making offers of material or financial gain (provided by either Anthem or a third-party source) to potential enrollees, including cash or cash equivalents, gifts that exceed \$10 per gift (or more with state approval), or are not also provided to the general public, or any gift or incentive that has not been pre-approved by DMS, as an inducement to enroll with Anthem, select a particular provider, or use a product.

3.11 Records Standards: Member Medical Records

The provider's medical records must conform to good professional medical practice and must be permanently maintained at the primary care site.

Members are entitled to one copy of the member's medical record each year, and the copy is provided at no cost to the member. Members or a member's representatives should have access to these records.

A member's medical record shall include (at a minimum for hospitals and mental hospitals):

- Identification of the beneficiary
- Physician name
- Date of admission and dates of application of Medicaid benefits (and date of authorization of Medicaid benefits, if application is made after admission)
- The plan of care (as required under 42 CFR 456.172 for mental hospitals and 42 CFR 456.70 for hospitals).
- Initial and subsequent continued stay review dates (described under 42 CFR 456.233 and 42 CFR 465.234 for mental hospitals, and 42 CFR 456.128 and 42 CFR 456.133 for hospitals)
- Reasons and plan for continued stay, if applicable
- Other supporting material the committee believes appropriate to include
- For non-mental hospitals only:
 - Date of operating room reservation
 - Justification of emergency admission, if applicable

A member's medical record should include the following minimal detail for individual clinical Encounters:

- History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health, and substance abuse status
- Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (EPSDT) are addressed from previous visits;
- Plan of treatment including:
 - Medication history, medications prescribed, including the strength, amount, directions for use and refills
 - Therapies and other prescribed regimen
 - Follow-up plans including consultation, referrals and directions, including time to return

3.11.1 Anthem's medical records standards include:

1. Patient identification information – patient name or ID number must be shown on each page or electronic file
2. Personal/biographical data – age, sex, address, employer, home and work telephone numbers, and marital status, date of birth, race or ethnicity, school, name and telephone numbers of emergency contacts and language spoken
3. Consent forms
4. Guardianship information
5. Date of entry and date of encounter
6. Provider identification by name
7. The consultation, laboratory, and radiology reports filed in the Medical Record should contain the ordering provider's initials or other documentation indicating review
8. Legibility – if someone other than the author judges it illegible, a second reviewer must evaluate it
9. Allergies – must note prominently
 - a. Medication allergies
 - b. Adverse reactions

- c. No known allergies (NKA)
- 10. Past medical history – for patients seen three or more times. Include serious accidents, operations, illnesses and prenatal care of mother and birth for children. For children, past medical history includes prenatal care and birth information, operations and childhood illnesses (i.e., documentation of chicken pox).
- 11. Immunizations – a complete immunization record for pediatric members age 20 and younger with vaccines and dates of administration pursuant to 902 KAR 2:060
- 12. Diagnostic information
- 13. Medical information – including medication history – medications prescribed, including the strength, dosage, instructions and refills, and instruction to patient
- 14. Identification of current problems:
 - a. Serious illnesses
 - b. Medical and behavioral conditions
 - c. Health maintenance concerns
- 15. Identification and history of nicotine, alcohol use or substance abuse
- 16. Documentation of reportable diseases and conditions to the local health department and/or department for public health serving the jurisdiction in which the patient resides or Department for Public Health pursuant to 902 KAR 2:020
- 17. Instructions – including evidence the patient was provided basic teaching and instruction for physical or behavioral health condition
- 18. Family planning information and records for each individual, including those minor patients
- 19. Smoking /alcohol/substance abuse – notation required for patients age 12 and older and seen three or more times
- 20. Consultations, recommendations for additional care and specialist reports – consultation, lab and x-ray reports must have the ordering physician’s initials or other documentation signifying review; any consultation or abnormal lab and imaging study results must have an explicit notation
- 21. Written denials of service and the reason for the denial
- 22. Emergencies – all emergency care and hospital discharge summaries for all admissions must be noted
- 23. Hospitals discharge summaries – must be included for all admissions while enrolled and prior admissions when appropriate
- 24. Follow-up visits provided secondary to reports of emergency room care
- 25. Advance directive – must document whether the patient has executed an advance directive such as a living will or durable power of attorney

3.11.2 Documentation Standards for an Episode of Care

When Anthem requests clinical documentation from the provider to support claims payments for services, the provider must ensure the information provided to Anthem:

- Identifies the member
- Is legible
- Reflects all aspects of care

To be considered complete, documentation for episodes of care will include, at a minimum, the following elements:

- Patient identifying information
- Consent forms
- Types and dates of physical examinations
- Laboratory reports
- Imaging reports (including X-ray)
- Surgical reports

- Diagnoses and treatment plans for individual episodes of care
- Physician orders
- Face-to-face evaluations
- Progress notes
- Health history, including drug applicable allergies
- Consultation reports
- Admission and discharge dates and instructions
- Preventive services provided or offered appropriate to the member's age and health status
- Evidence of coordination of care between primary and specialty physicians

Refer to the standard data elements to be included for specific episodes of care as established by The Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A single episode of care refers to continuous care or a series of intervals of brief separations from care to a member by a provider or facility for the same specific medical problem or condition.

Documentation for all episodes of care must meet the following criteria:

- Is legible to someone other than the writer
- Contains information that identifies the member on each page in the medical record
- Contains entries in the medical record that are dated and include author identification (for example, handwritten signatures, unique electronic identifiers or initials)

3.11.3 Other documentation not directly related to the member:

Other documentation not directly related to the member but relevant to support clinical practice may be used to support documentation regarding episodes of care, including:

- Policies, procedures and protocols
- Critical incident/occupational health and safety reports
- Statistical and research data
- Clinical assessments
- Published reports/data

Anthem may request that the provider submit additional documentation, including medical records or other documentation not directly related to the member, to support claims the provider submitted. If documentation is not provided following the request or notification or if documentation does not support the services billed for the episode of care, Anthem may:

- Deny the claim
- Recover and/or recoup monies previously paid on the claim

Anthem is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.

3.12 Records Standards: Patient Visit Data

The provider must provide:

1. A history and physical exam with both subjective and objective data for presenting complaints
2. Behavioral health treatment, including at-risk factors:
 - Danger to self/others
 - Ability to care for self
 - Affect

- Perpetual disorders
 - Cognitive functioning
 - Significant social health
3. Admission or initial assessment must include:
 - Current support systems
 - Lack of support systems
 4. Behavioral health treatment — documented assessment at each visit for client status and symptoms, indicating:
 - Decreased
 - Increased
 - Unchanged
 5. A plan of treatment, including:
 - Activities
 - Therapies
 - Goals to be carried out
 6. Diagnostic tests
 7. Behavioral health treatment — evidence of family involvement in therapy sessions and/or treatment
 8. Follow-up care encounter forms or notes indicating follow-up care, call or visit in weeks, months or PRN
 9. Recommendations for additional care and results of all other aspects of patient care and ancillary services

3.12.1 Medical Records for EPSDT Screenings and Special Services

The EPSDT provider shall maintain a medical record for each child screened or treated with all entries kept current, dated and signed by professional providing the service or counter-signed by supervising professional. The record shall include the following:

1. Child's medical history (including birth history)
2. Physical development and mental development/assessment findings
3. Growth and development records
4. Record of immunizations and laboratory tests (including negative results)
5. Follow-up information on recommendations for additional care and treatments
6. Documentation of parental or guardian refusal of EPSDT screenings or special services

3.12.2 Review and Audit of Medical Records

The provider shall make available the medical records for review and shall comply with audit procedures based on the Policy: *Medical Record Requirements - KY*.

Anthem systematically reviews medical records to ensure compliance and institutes actions for improvement when Anthem standards are not met.

Anthem maintains a professional recordkeeping system for member services. Anthem makes all medical management information available to health professionals and state agencies and retains these records for seven years from the date of service.

Anthem (Anthem) providers are encouraged to sign an agreement with the Kentucky Health Information Exchange (KHIE) within one month of becoming effective with Anthem. By connecting an electronic

health records system to the KHIE, summary of care records are shared with other providers connected to the KHIE. The ultimate objective is to facilitate improved care coordination resulting in higher quality care and better outcomes. The data set required for submission is a Summary of Care Record. If you do not have an electronic health records system, you are still required to enter into an agreement with KHIE and elect for direct secure messaging services. This allows clinical information to be shared securely with other providers in the community of care. Hospitals are also required to submit admission, discharge and transfer (ADT) messages to KHIE.

3.13 Rights and Responsibilities of Anthem Members

Anthem members have rights and responsibilities. Anthem’s Member Services representatives serve as member advocates and may be contacted to discuss these rights and responsibilities. Member Services can assist members in understanding and exercising rights. Outlined below are the rights and responsibilities of members:

Member Rights
<p>General Member Rights</p> <p>Members have the right to:</p> <ul style="list-style-type: none"> • Get understandable notices or have program materials explained or interpreted • Receive timely information about the health plan, its services, its practitioners and providers, and member rights and responsibilities • Get courteous, prompt answers from the health plan and DMS • Be treated with respect • Have privacy protected by DMS, the health plan and its providers • Get information about all medical services covered • Be informed of EPSDT screenings and Special Services • Be informed (along with the member’s families, if applicable), both upon initial enrollment and annually thereafter, about the right to appeal any decisions related to Medicaid services (including EPSDT services) • Choose individual health plans and primary care providers from among available health plans and contracted networks • Receive proper medical care consistent with the Anthem member handbook and without discrimination regarding health status or conditions, gender, ethnicity, race, marital status or religion • Get all medically necessary covered services and supplies listed in the Anthem schedule of benefits, subject to the limits, exclusions and cost-sharing described in the member handbook • Take part in decisions about the member’s healthcare and children’s healthcare, including having candid discussions of appropriate or medically necessary treatment options, regardless of cost or coverage • Get medical care without long delays • Refuse treatments and be told of the possible results of refusing treatments, including whether refusals may result in disenrollment from Anthem • Expect records and children’s records and conversations with providers to be kept confidential • Get second opinions by other providers within health plans when the member disagrees with the initial providers’ recommended treatment plans

Member Rights

- Make complaints or grievances about the health plans or providers and receive timely answers
- File appeals with health plans if the member is not satisfied with the health plans' decisions
- Request a state fair hearing
- Change primary care providers
- Exercise rights without Anthem or its providers treating the member adversely

Informed Consent

Members also have the right to:

- Give consent to treatment or care
- Give consent for or refusal of treatment and active participation in decision choices
- Ask providers about the side effects of care for the member or the member's children
- Know about side effects of care and give consent before getting care for the member or the member's children

Advance Directives

Members also have the right to use advance directives to put healthcare choices into writing.

Members may also name someone to speak for them if that member is unable to speak.

State law has two kinds of advance directives:

- Durable power of attorney for healthcare — names someone to make medical decisions for the member if he or she is not able to make his or her own decisions
- Directive to physicians (living will) — tells the doctor/doctors what a member does or does not want if/when a terminal condition arises or if the member becomes permanently unconscious

Privacy

Members also have the right to:

- Be treated with respect and with due consideration for the member's dignity and privacy
- Expect that Anthem will treat member records (including medical and personal information) and communications confidentially
- Request and receive a copy of the member's medical records at no cost to the member and request that the records be amended or corrected
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation as specified in federal regulations

Grievances, Appeals and Fair Hearings

Members also have the right to:

- Pursue resolution of grievances and appeals about the health plan or care provided
- Freely exercise the right to file a grievance or an appeal without it adversely affecting the way the member is treated
- Continue to receive benefits pending the outcome of an appeal or a fair hearing under certain circumstances
- File a grievance with Anthem if dissatisfied with Anthem advance directive policy and procedure or Anthem administration of policy and procedure

Member Rights

Anthem Information

Members also have the right to:

- Receive the necessary information to be an Anthem member in a manner and format the member can understand easily
- Receive a current member handbook and a provider directory
- Receive assistance from Anthem in understanding the requirements and benefits of the plan
- Receive notice of any significant changes in the benefit package at least 30 days before the intended effective date of the change
- Make recommendations about Anthem's rights and responsibilities policies
- Know how Anthem pays providers

Medical Care

Members also have the right to:

- Choose primary care providers (PCPs) from Anthem network of providers and can change the chosen PCP 90 days after the initial assignment. Members may change PCP once a year regardless of reason and at any time for cause.
- Members can select or be assigned to a new PCP when the change is mutually agreed to by Anthem and the Member, when a PCP is terminated from coverage, or when a PCP change is part of the resolution to an appeal.
- Choose any Anthem network specialist after getting a recommendation for additional care from the member's PCPs, if appropriate
- Be referred to healthcare providers for ongoing treatment of chronic disabilities
- Have access to PCPs or backups 24 hours a day, 365 days a year for urgent or emergency care
- Get care right away from any hospital when the member's symptoms meet the definition of an emergency medical condition
- Get post-stabilization services following an emergency medical condition in certain circumstances
- Be free from discrimination and receive covered services without regard to race, color, creed, gender, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, physical or behavioral disability, or whether advance directives have been issued except where medically indicated
- Seek services from a participating Indian health service, tribally-operated facility/program or urban Indian clinic (for Native American members enrolled in Anthem).
- Any Indian enrolled with the contractor eligible to received services from a participating I/T/U provider or a I/T/U primary care provider shall be allowed to received services from that provider if part of provider network

Member Responsibilities

General Member Responsibilities

Members and/or the member's enrolled dependents have the responsibility to:

- Accurately and promptly report changes that may affect premiums or eligibility such as address changes or changes in family status or income and submit the required forms and documents

Member Responsibilities

- Choose a primary care provider before receiving services
- Work with Anthem to help get any third-party payments for medical care
- Tell Anthem about any outside sources of healthcare coverage or payments such as insurance coverage for accidents
- Tell primary care providers about medical problems and ask questions about things members do not understand
- Decide whether to receive treatments, procedures or services
- Get medical services from (or coordinated by) primary care providers, except in emergencies or in the cases of recommendations for additional care
- Get recommendations for additional care from primary care providers before going to specialists
- Timely recommendations for additional care and access to medically indicated specialty care
-
- Pay deductibles and coinsurance in full when due
- Not engage in fraud or abuse in dealing with Anthem, the Maternity Benefits program, the health plan, primary care providers or other providers
- Report suspected Fraud and Abuse
- Keep appointments and be on time or call the providers' offices when late or cancelling appointments
- Keep medical ID cards the member's self at all times
- Notify the health plan or primary care providers within 24 hours or as soon as reasonably possible regarding any emergency services provided outside the health plan
- Use only contracted health plan and primary care providers to coordinate services for medical needs
- Comply with requests for information, including requests for medical records or information about other coverage by the date requested
- Cooperate with primary care providers and referred providers by following recommended procedures or treatments
- Work with the health plan and providers to learn how to stay healthy

Respect and Cooperation

Members and/or the member's enrolled dependents also have the responsibility to:

- Treat doctors, doctors' staff and Anthem employees with respect and dignity
- Not be disruptive in the doctor's office
- Make and keep appointments and be on time or call to cancel
- Call if there is a need to cancel an appointment or change the appointment time or call if the member will be late
- Respect the rights and property of all providers
- Tell providers about symptoms, problems and ask questions
- Supply information providers need in order to provide care
- Understand the specific health problems and participate in developing mutually agreed upon treatment goals as much as possible
- Discuss problems the member may have with following providers' directions

Member Responsibilities

- Follow plans and instructions for the care the member has agreed to with practitioners
- Consider the outcome of refusing treatment recommended by a provider
- Discuss grievances, concerns and opinions in an appropriate and courteous way
- Help providers obtain medical records from previous providers and help providers complete new medical records as necessary
- Secure recommendations for additional care from PCPs when specifically required before going to another healthcare provider unless the member has a medical emergency
- Know the correct way to take medications
- Go to the emergency room when the member has an emergency
- Notify PCPs as soon as possible after the member receives emergency services
- Tell doctors who the member wishes to receive individualized health information

Anthem Policies

Members and/or the member's enrolled dependents also have the responsibility to:

- Provide Anthem with proper identification during enrollment
- Carry Anthem and Medicaid ID cards at all times and report any lost or stolen cards
- Contact Anthem if information on ID cards is wrong or if there are changes to the member's name, address or marital status
- Call Anthem and change PCP before seeing the new PCP
- Tell Anthem about any doctors the member is currently seeing
- Notify Anthem if a member or family member who is enrolled in Anthem has died
- Report suspected fraud and abuse

Chapter 4: Tools To Help Manage Anthem Members

4.1 Verifying Member Eligibility

There are a few options for verifying member eligibility:

- Panel Reports, Availity Essentials: [Availity.com](https://www.availity.com)
- Provider Services: **855-661-2028**
- Kentucky Health Net: sso.kymmis.com

To verify member eligibility, log on to Availity at [Availity.com](https://www.availity.com). From Availity's homepage, select Patient Registration > Eligibility & Benefits.

The provider should verify the eligibility of each member receiving treatment in the provider's office and that the member appears on the provider's panel report. Accessing the panel report via Anthem's provider website is the most accurate way to determine member eligibility. There is secure access to an electronic listing of the provider's panel of assigned members, once the provider has registered, by logging in to providers.anthem.com/ky.

In addition, Kentucky Health Net provides member eligibility status and any applicable eligibility warning flags.

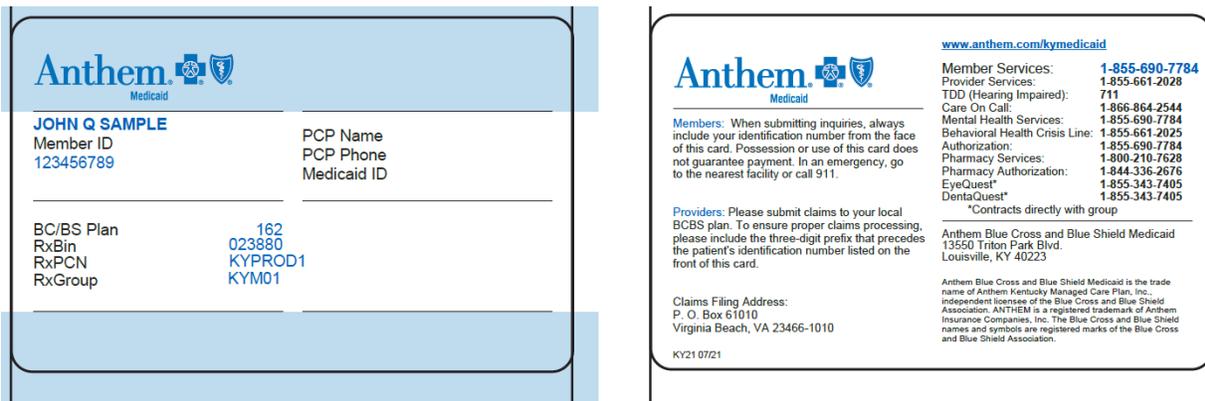
To request a hard copy of provider panel listing be mailed to the provider, call Provider Services at **855-661-2028**.

4.2 Member Copay Requirements

KRS 205.6312 states that Medicaid members are no longer responsible for co-pays/cost sharing.

4.3 Member Identification Cards

Member identification card samples:



Please note: The Anthem member identification number begins with XTF.

4.4 Automatic Assignment of Primary Care Providers

During enrollment, a member can choose his or her primary care provider (PCP). When a member does not choose a PCP at the time of enrollment or is automatically assigned to Anthem, he or she has 90 days to select a PCP. If a PCP is not selected one will be auto- assigned. When a member transfers from another MCO and the PCP ID is supplied, Anthem will assign the member to that PCP if they are participating and meet panel requirements.

PCP auto-assignments are based on proximity to members' home addresses as well as ages, genders and primary spoken languages. If a member loses coverage for a period of time and is reinstated with Anthem, he or she will be assigned to the most recent provider that was previously assigned to him or her.

Members receive an Anthem-issued ID card that displays the PCP name and phone number, in addition to other important plan contact information.

4.4.1 Procedure for Changing PCPs or Other Providers

Members have the right to change the chosen PCP 90 days after the initial assignment and once a year thereafter, regardless of reason, and at any time for any reason as approved by Anthem. Members may also change the chosen PCP if:

- There has been a temporary loss of eligibility, and this loss caused the member to miss the annual opportunity.
- Medicaid or Medicare imposes sanctions on the PCP.
- The member and/or the PCP are no longer located in the same Medicaid region.

Members also have the right to change PCP at any time for cause. Good cause includes:

- The member was denied access to needed medical services.
- The member received poor quality of care.
- The member does not have access to qualified providers to treat his or her healthcare needs.

If Anthem approves the member's request, the assignment will occur no later than the first day of the second month following the month of the request.

To select or change a PCP, members may call Member Services at **855-690-7784** (TTY 711), 7 a.m. to 7 p.m. Eastern time Monday through Friday, except holidays. The Member Handbook includes a description of how to choose a PCP and how to change a PCP. PCP change requests are generally processed on the same day or by the next business day, and a new ID card is issued. The member may also change their PCP on our Member Portal at mss.anthem.com/ky.

Primary Care Dentist (PCD)

A Primary Care Dentist (PCD) dental home has been assigned to members and added to their individual insurance card. The dental home assignment will assist PCP with referral to a local dentist within the access range. To change a PCD, members may call Member Services at **855-690-7784** (TTY 711), 7 a.m. to 7 p.m. Eastern time Monday through Friday, except holidays or DentaQuest at 1- 855-343-7405 (TTY 711), 7 a.m. to 7 p.m. Eastern time Monday through Friday, except holidays.

4.5 Missed Appointments

At times, members may cancel or not attend necessary appointments and fail to reschedule, which can be detrimental to the member's health. The provider should attempt to contact any member who has not shown up for or canceled an appointment without rescheduling. Contact the member by telephone to:

- Educate him or her about the importance of keeping appointments
- Encourage him or her to reschedule the appointment

Providers are not permitted to charge members for missing or cancelling appointments, even if it is the provider's policy. Providers may not seek reimbursement for a missed or canceled appointment. Instead, Anthem Kentucky Medicaid is asking providers to document and report missed or canceled appointments for monitoring purposes on KYHealthNet.

For members who frequently cancel or fail to show up for appointments, please call Provider Services at **855-661-2028** to address the situation. Anthem's goal is for members to recognize the importance of maintaining preventive health visits and to adhere to a plan of care recommended by the member's individual primary care providers (PCPs).

4.6 Nonadherent Members

Contact Provider Services (**855-661-2028**) if there is an issue with a member regarding:

- Behavior
- Treatment cooperation
- Completion of treatment
- Continuously missed or rescheduled appointments

Anthem will contact the member to provide the education to address the situation and will report the outcome of any educational efforts.

4.7 Second Opinions

A member, parent and/or legally appointed representative or the member's PCP may request a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition. The second opinion shall be provided at no cost to the member.

The second opinion must be obtained from an Anthem network provider (see Provider Referral Directory) or a non-network provider if there is not a network provider with the expertise required for the condition. Authorization is required for a second opinion if the provider is not a network provider. Once approved, the PCP will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. The PCP will notify the member of the outcome of the second opinion.

Anthem may also request a second opinion at Anthem's own discretion. This may occur under the following circumstances:

- Whenever there is a concern about care expressed by the member or the provider
- Whenever potential risks or outcomes of recommended or requested care are discovered by the plan during Anthem's regular course of business
- Before initiating a denial of coverage of service
- When denied coverage is appealed
- When an experimental or investigational service is requested

When Anthem requests a second opinion, Anthem will make the necessary arrangements for the appointment, payment and reporting. Anthem will inform the PCP and the member of the results of the second opinion and the consulting provider's conclusion and recommendation(s) regarding further action.

4.8 Member Grievances

Anthem members have the right to say they are dissatisfied with Anthem or a provider's service and operations. A member or member's authorized representative or provider may file a grievance any time there is an issue or concern. Providers who file a grievance on behalf of a member require written approval from the member represented.

A member can file a grievance orally by calling Member Services at **855-690-7784 (TTY 711)**. He or she can also file a grievance by mail. Any supporting documents must be included. Grievances should be sent to:

Attention: Quality Management
Anthem
13550 Triton Park Blvd., Third Floor
Louisville, KY 40223

Member grievances do not involve:

- Medical management decisions
- Interpretation of medically necessary benefits
- Adverse determinations

These are appeals and are addressed in the appeals section.

Anthem will acknowledge receipt of each grievance, either orally or in writing, within five business days. An acknowledgement letter is mailed within five business days of receiving a written grievance, and does not imply that a decision has been made on the grievance.

Anthem investigates each grievance and resolves within specific time frames. Urgent or emergent grievances are resolved within 72 hours of receipt, all other grievances are resolved within 30 calendar days from the date Anthem received the grievance.

If more information is needed, we may extend the resolution process an additional 14 calendar days and at that time, Anthem will contact the member by phone and by written notice within two calendar days of the reason for the decision to extend the time frame. The member will be given his or her right to file another grievance if he or she disagrees with that decision.

Anthem will notify the member in writing of:

- The name(s), title(s) and in the case of a grievance with a clinical component, qualifying credentials of the person or persons completing the review of the grievance.
- Anthem's decision.
- The reason for the decision.
- Policies and procedures regarding the decision.
- The right to further remedies allowed by the law.
- The process to use when contacting the CHFS Ombudsman's office regarding grievances.
- How the member may be advised or represented by a law advocate, attorney or other representative as chosen by the member and agreed to by the representative.

Grievance resolution time frames can be extended by 14 days if the member requests the extension or Anthem determines it is in the best interest of the member. Anthem will submit in writing to the member the reason for the extension.

Members do not have the right to hearings in regard to the disposition of grievances.

4.9 Lock-In Program

The Lock-In program has been designed to address and contain member overutilization of services, for pharmacy and nonemergent care provided in an emergency setting. This program restricts members to receiving healthcare services from designated providers, which may include one primary care provider (PCP), one controlled substance prescriber, one specific pharmacy and/or one hospital for nonemergency, outpatient services.

Members will be restricted for an initial 24 month Lock-In period and thereafter, reviewed at least annually to determine whether to release or continue Lock-In.

Providers will receive a letter informing them of their responsibilities for providing care to a restricted member. The provider letter will contain:

- Member demographics and plan ID number.
- General information on the restriction process.
- Identification of the provider(s) the member is being restricted to.
- Date the restriction will start and time period of the restriction.
- The provider's management responsibilities.
- A summary of the Lock-In program and what this means for the member that has been restricted.

The Lock-In physician is the primary prescribing physician. Narcotics and controlled substances should only be prescribed by the Lock-In physician or approved by his or her specific referral to a specialist. Lock-In providers are never required to provide services or medications not supported by medical necessity.

The member will only be allowed to access covered services from designated Lock-In providers, except in the case of emergencies or if the member has been referred to an alternate provider authorized by Anthem or the PCP. The member is allowed to access services from providers who are covering for the Lock-In provider(s) or providers who were referred by their Lock-In provider.

The member is expected to actively share in the Lock-In responsibility by only receiving healthcare, prescription medications and hospital outpatient services from the assigned Lock-In providers. If the Lock-In member fails to follow medical advice, then the Lock-In providers are not required to provide requested referrals or treatment.

Providers should utilize the Kentucky Health Net website to check Medicaid eligibility and Lock-In status prior to rendering nonemergency services. If the member accesses nonemergency services from a non-Lock-In provider, the member will be held responsible for payment of those medical bills if the provider informs the member that they are financially responsible before the service(s) is rendered.

Nonemergency services rendered by providers who are not the assigned Lock-In provider without obtaining the written permission of assigned Lock-In providers via referral will result in a denied claim. The member must always coordinate services through their assigned Lock-In providers.

Members may appeal a restriction decision by submitting an appeal in writing or verbally to Anthem within 60 days of the original notice. Oral appeals must be followed by a written appeal.

Chapter 5: How Anthem Supports Its Members

5.1 Anthem as the Member Health Home

Member Health Home (MHH) means the development and use of an interdisciplinary team that addresses the full breadth of clinical and social service expertise for members with complex chronic conditions, substance use disorder issues, and/or long-term service needs and supports. The multidisciplinary team includes providers from the local community that authorize Medicaid, state or federally funded mental health, long-term services and supports, chemical dependency and medical services.

Anthem is considered to be the MHH for those enrolled in Anthem . Anthem ensures coordinated healthcare is provided for children or adult members with special healthcare needs by primary care providers (PCPs), other designated providers, teams of health professionals or health teams. At a minimum, health home services include:

- Comprehensive care management, including, but not limited to, chronic condition care (care management services provided as part of the MHH will not duplicate case management services provided for the purpose of determining eligibility for services, care planning and authorization of services)
- Self-management support for the member, including parents of caregivers or parents of children and youth
- Care coordination and health promotion
- Multiple ways for the member to communicate with the PCP or team, including electronically and by phone
- Education of the member and his or her parent or caregiver about self-care, prevention and health promotion, including the use of patient decision aids
- Enrollee and family support, including authorized representatives
- The use of information technology to link services, track tests, generate patient registries and provide clinical data
- Linkages to community and social support services
- Comprehensive transitional healthcare, including follow-up from inpatient to other settings
- A single plan that includes all members' treatments and self-management goals and interventions
- Ongoing performance reporting and quality improvement

5.2 Care on Call

Care on Call is a telephonic, 24-hour triage service Anthem members can call to speak with a registered nurse who can help them:

- Assist members with health related questions or concerns
- Give home care advice for a condition that can safely be treated by the member
 - Advise if any health concern can wait to be seen during normal business hours or if a walk-in clinic or emergency room (ER) care is indicated

Anthem encourages the provider to tell Anthem members about this service and share with them the advantages of avoiding the ER when a trip there isn't necessary or the best alternative.

Members can reach Care on Call at **866-864-2544 (TTY 711)**. TTY services are available for the deaf and hard of hearing, and language translation services are also available.

5.3 Advance Directives

Anthem respects the right of the member to control decisions relating to his or her own medical care, including the decision to have the medical or surgical means or procedures calculated to prolong life provided, withheld or withdrawn. This right is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession.

Anthem adheres to the Patient Self-determination Act and maintains written policies and procedures regarding advance directives. Advance directives are documents signed by a competent person giving direction to healthcare providers about treatment choices in certain circumstances. Anthem recognizes and supports the following advance directives:

- Durable power of attorney
- Living will

A durable power of attorney lets a member name a patient advocate to act on his or her behalf. A living will lets a member state his or her wishes on medical treatment in writing.

Anthem encourages members age 18 and older to ask the provider for an Advance Directive form and education at the member's first appointment. Please document the member's forms in the provider's medical records.

Anthem understands a facility or physician may conscientiously object to an advance directive. However, Anthem also recognizes the member's right to determine his or her own care.

Please note that an Anthem associate cannot act as a witness to an advance directive nor serve as a member's advocate or representative.

Additional information about a living will/durable power of attorney or Do Not Resuscitate Order can be found chfs.ky.gov.

5.4 Case Management Services

Case Management focuses on the timely, proactive, collaborative, and member-centric coordination of services for individuals. These individuals can be identified with complex medical conditions, repeated admissions for the same condition, or high risk obstetrics. Anthem assists members who are found to have potentially preventable emergency department utilization and those who qualify for the Lock-In Program.

The **defining features** of Anthem's case management programs are:

- A collaborative process that includes contact with the member, family member, caregiver and physician or other healthcare providers.
- A process carried out using communication and available resources with the goal of promoting quality and effective outcomes.

- A process that assists in optimizing the members' healthcare outcomes through plans designed to empower members to use the benefits, services and options available to meet individual health needs.

5.4.1 Anthem's Case Management Programs

Complex Case Management is the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

Post-Discharge Management is part of the continuum of care provided to Anthem members. Post-Discharge helps Case Managers focus interventions on behaviors that can help prevent readmissions. This program focuses member education which leads to self- management of post discharge needs including completion of a personal health record, medication reconciliation and follow-up appointments, necessary home care and community resources.

High-Risk OB (HROB) and NICU Case Management are focused on pregnant members identified by early OB assessment as being at risk for an early delivery or poor birth outcome influenced by a known maternal or fetal condition or risk factor. The goal of HROB CM is to modify the risk of early delivery or poor maternal or neonatal outcome. The goal of NICU Case Management is minimize the risk of readmission for preventable conditions and to encourage appropriate follow-up care through the first months of life.

Lock-In Case Management is based on the identification of members with a pattern of overutilization of controlled medications and/or of the ER. This case management program arises from Kentucky Regulation 907 KAR 1:677, Medicaid Recipient Lock-In Program. The goal of Lock-In CM is to assist members in the appropriate use of controlled medications and/or ER. Reference section 4.8 for additional details related to the Lock-In Program.

The Case Management Process: Anthem's Case Managers perform the activities of assessment, planning, facilitation and support throughout the continuum of care and provide evidenced-based, member-centric care planning that is consistent with recognized standards of case management practice and accreditation requirements.

Case managers consider Anthem members' needs for:

- Social determinants of health
- Behavioral Health services
- Educational services
- Therapeutic services
- Other nonmedical support services (WIC,NEMT)

Non-emergency medical transportation (NEMT) is a **Medicaid** benefit designed to provide **transportation** to and from medical appointments for members who have no other means of **transportation** (42 CFR 431.53). Members receive safe and reliable transportation to Medicaid Covered Services. Our case management team can refer members for NEMT.

Anthem's Case Management team will also assist the member in completing a health risk assessment. The health risk assessment includes questions regarding social determinants of health, health equity, mental health and substance use disorders screenings.

The Anthem Case Manager will develop a person centered Care Plan in accordance with 42 C.F.R. 438.208. A member's Care Plan, at a minimum, includes:

- Appropriate medical, behavioral, and social services and be consistent with the PCP's medical diagnosis and clinical treatment plan;
- Person-centered goals, objectives and desired wellness, health, functional, and quality of life outcomes for the Enrollee and how services are intended to help achieve these goals;
- A description of Enrollee's psychosocial needs including any housing or financial assistance needs
- SDoH; how such needs will be addressed to ensure the member's ability to live safely in the community;
- Social, educational, and other services needed by the member
- Enrollee risk factors and measures in place to minimize them; and
- Planned Interventions.

The Care Plan is documented and made available to the member and the multi-disciplinary care team, including the member's PCP as appropriate. The case manager will provide a copy of the completed Enrollee Needs Assessment and Care Plan to the member and any other providers authorized to deliver services to or for the benefit of the member and as documented in the Care Plan.

A Care Plan will be routinely updated and incorporate input from the multidisciplinary care team and the member.

Anthem welcomes provider recommendations for additional care of patients who can benefit from Anthem's case management support. Please call the Anthem Provider Services toll-free number **855-661-2028** and request the Kentucky Case Management team or email **Kentuckycm@anthem.com**. Anthem's Case Managers are licensed registered nurses and social workers. Case Managers are available from 8 a.m. to 5 p.m. Eastern time. Confidential voicemail is available 24 hours a day.

5.5 Condition Care

Anthem's Condition Care (CNDC) is based on a system of coordinated care management interventions and communications designed to help physicians and others managing members with chronic conditions. The programs include a holistic, focusing on the needs of the member through telephonic and community-based resources. Motivational interviewing techniques used in conjunction with member self-empowerment. The ability to manage more than one condition to meet the changing healthcare needs of our member population. Anthem's condition care programs include:

- Asthma
- Bipolar disorder
- Chronic obstructive pulmonary disorder (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- HIV/AIDS
- Hypertension
- Major depressive disorder – adult
- Major depressive disorder – child/adolescent
- Schizophrenia

- Diabetes
- Substance use disorder

In addition to condition-specific condition care programs, our member-centric, holistic approach also allows us to assist members with Obesity with weight management programs, tobacco use and smoking cessation education and Cancer Care Navigation.

Health Management: Healthy Families Program

Healthy Families is a six-month program for children 7 to 17 years of age who are overweight, obese, or at risk of becoming overweight or obese. Healthy Families includes coaching using motivational interviewing, lifestyle education and written materials to support member-identified goals. Members can be referred to the program by calling **844-425661**.

5.5.1 Program Features

- Proactive identification process
- Program content is based on evidence-based clinical practice guidelines
- Collaborative practice models to include physician and support providers in treatment planning
- Continuous self-management education
- Ongoing communication with providers regarding patient status
- Nine of our Condition Care programs are National Committee for Quality Assurance accredited and incorporate outreach, education, care coordination and follow-up to improve treatment compliance and enhance self-care

Condition care clinical practice guidelines are located at providers.anthem.com/ky. A copy of the guidelines can be printed from the website.

5.5.2 Who is Eligible?

Members with one or more of the above listed conditions are eligible for CNDC services.

As a valued provider, Anthem welcomes provider referrals of patients who can benefit from additional education and care management support. Anthem case managers will work collaboratively with the provider to obtain input in the development of care plans. Members identified for participation in any of the programs are assessed and risk stratified based on the severity of the member's condition. Members are provided with continuous education on self-management concepts, which include primary prevention, coaching 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.

5.5.3 Condition Care (CNDC) Provider Rights and Responsibilities

Providers have the right to:

- Have information about Anthem, including:
- Provided programs and services
 - Anthem staff
 - Anthem staff's qualifications
 - Any contractual relationships
- Decline to participate in or work with any of Anthem's programs and services for the provider's patients

- Be informed of how Anthem coordinates interventions with the provider's patients' treatment plans
- Know how to contact the person who manages and communicates with the provider's patients
- Be supported by Anthem's organization when interacting with patients to make decisions about the member's healthcare
- Receive courteous and respectful treatment from Anthem staff
- Communicate complaints about CNDC (see the Anthem Provider Complaint and Grievance Procedure)

5.5.4 Hours of Operation

Anthem's CNDC case managers are registered nurses and are available Monday through Friday from 8:30 a.m. to 5:30 p.m. ET. Confidential voicemail is available 24 hours a day.

Providers can email us at **Condition-Care-Provider-Referrals@anthem.com** or call a CNDC team member at **888-830-4300**. Refer to our provider website for additional information about CNDC providers.anthem.com/ky.

5.6 Enrollment

Medicaid recipients who meet the state's eligibility requirements for participation in managed care are eligible to join Anthem. Members are enrolled without regard to individual health status. Anthem members:

- May change the chosen Managed Care Organization (MCO) within the first 90 days, and then once a year thereafter
- Can choose primary care providers (PCPs) and will be auto-assigned to PCPs if the member does not select PCPs
- Are encouraged to make appointments with the chosen PCPs within 90 calendar days of the effective dates of enrollment

Eligible newborns born to members are automatically enrolled with Anthem on the date of birth if the mother of the newborn was enrolled with Anthem before the birth and has not made an alternative MCO or PCP selection. Anthem is responsible for all covered medically necessary services to the qualified newborn.

5.7 Language and Translation Services

At no cost to the provider or member, interpreter services are available to members who are hearing impaired or are non-English speaking. Information about language and translation services is available by contacting Anthem Member or Provider Services.

Services include:

- Telephonic and face-to-face interpretation services
- TDD/TYY Services for those with a hearing impairment

For face-to-face interpretation, please contact Anthem Provider Service **855-661-2028** and ask for Case Management.

Members can call the Relay Service at **711**. Visit [fcc.gov/encyclopedia/trs-providers](https://www.fcc.gov/encyclopedia/trs-providers) for a list of Video Relay Service Providers.

Services provided at or by Public Health departments or public entities: public entities, such as Public Health departments, are responsible for payment for interpreter services provided at the provider facilities or affiliated sites.

5.8 Provider Directories

Anthem makes provider directories available to members in online searchable and hard-copy formats. Since use of these directories is how members identify healthcare providers near them, it is important that the practice address/addresses, providers' names and contact information are promptly updated when changes occur.

5.9 Welcome Call

Anthem gives new members a welcome call to:

- Educate them about Anthem's services
- Help them schedule initial checkups
- Identify any health issues (for example, pregnancy or previously diagnosed diseases)
- Assess understanding of new member materials

Chapter 6: Covered Services for Members

6.1 Anthem Program Information

The Kentucky Cabinet for Health and Family Services (CHFS) offers the Medicaid program for Temporary Assistance for Needy Families (TANF), for Children’s Health Insurance Program (CHIP), as well as the eligible population through the Affordable Care Act (ACA) expansion.

6.2 Services Covered Under the State Plan or Fee-for-Service Medicaid

Some services are covered by the Kentucky fee-for-service Medicaid program instead of Anthem.

Even though Anthem does not cover these services, primary care providers (PCPs) or specialists will:

- Provide all required recommendations for additional care
- Assist in setting up these services for members

These services will be paid for on a fee-for-service basis, and include:

- Home- and community-based services for older and physically disabled persons
- Long-term care services

For details on how and where members can access these services, call the Cabinet for Health and Family Services Medicaid customer service line at **502-654-4321 (TTY 800-627-4702)**.

6.3 Services Covered Under Anthem

Anthem provides covered services that enable members to achieve age-appropriate growth and development, and they enable the member to attain, maintain or regain functional capacity.

Anthem will ensure direct access for any Member to a Provider, qualified by experience and training, to provide Family Planning Services. Anthem will not restrict a Member’s choice of his or her provider for Family Planning Services. Anthem will ensure access to any qualified provider of Family Planning Services without requiring a referral from the PCP.

A sample of covered services includes:

Note: Some services may require preauthorization; visit Anthem’s provider self-service site for additional information and requirements prior to performing service. For the most up-to-date precertification/notification requirements go to providers.anthem.com/ky.

Covered Benefits
Alternative Birthing Center Services (907 KAR 1:180)
Ambulatory Surgical Care Services (907 KAR 1:008)
Behavioral Health/Substance Abuse Services
Cardiac Rehabilitation (907 KAR 3:125)
Chemotherapy
Chiropractic Services (907 KAR 3:125)

Covered Benefits
Community Mental Health Center Services (907 KAR 1:046)
Circumcision
Dental Services (907 KAR 1:026)
Dermatology
Diagnostic Testing
Durable Medical Equipment (DME) (907 KAR 1:479)
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Visit (907 KAR 11:034)
Educational Consultation
Emergency Room
End Stage Renal Dialysis Services
ENT Services (Otolaryngology)
Family Planning/Sexually Transmitted Infection (STI) Care (907 KAR 1:048 & 1:434)
Gastroenterology Services
Gynecology (also see Obstetrical Care)
Hearing Services, including hearing aids for members under age 21 (907 KAR 1:038)
Home Healthcare (907 KAR 1:030)
Hospice services (non-institutional only) (907 KAR 1:330 & 1: 436)
Hospital Admission (907 KAR 10:012)
Independent Laboratory Services (Outpatient) (907 KAR 1:028)
Medical Detoxification
Medical Supplies (907 KAR 1:479)
Medical Injectable
Neurology
Observation
Obstetric Care
Ophthalmology
Oral Maxillofacial
Out-of-Area/Out-of-Network Care — requires prior authorization
Outpatient Hospital and Ambulatory Surgery
Outpatient Mental Health Centers
Pain Management/Psychiatry/Physical Medicine and Rehabilitation
Pharmacy and Limited Over-the-Counter Drugs including Mental/Behavioral Health Drugs (907 KAR 1:019, KRS 205.5631, 205,5632, 205.560)
Podiatry Services (907 KAR 1:270)
Preventative Health Services (907 KAR 1:360)
Psychiatric Residential Treatment Facilities (Level I and II) (907 KAR 9:005)
Radiology Services
Rehabilitation Therapy (Short Term): OT, PT, RT and ST
Sleep Studies 907 KAR 3:005
Sterilization (42 CFR 441.250 & KRS 205.560)
Transplantation (907 KAR 1:350)
Targeted Case Management (907 KAR15:005, 907 KAR 15:040 - 15:065)
Transportation to Covered Services, including Emergency and Ambulance Stretcher Services (907 KAR 1:060)
Tobacco Cessation Services (907 KAR 3:215)
Urgent Care Center, Urgent and Emergency Care Services
Vision Care, including Vision Examinations, Services of Opticians, Optometrists and Ophthalmologists, including eyeglasses for members (907 KAR 1:632)
Well-woman Exam

6.4 Anthem Special Services

Anthem covers extra benefits, including but not limited to the following, which eligible members cannot receive from fee-for-service Medicaid. These extra benefits are called special services.

Covered Special Services	Description and Coverage Limits
<p>Care on Call</p>	<p>Care on Call is a telephonic, 24-hour triage service that Anthem patients can call to speak with a registered nurse.</p> <p>Anthem encourages the provider to tell Anthem members about this service and share with them the advantages of avoiding the emergency room when a trip there isn't necessary or the best alternative.</p> <p>Members can reach Care on Call at 866-864-2544. TTY services are available for the hearing impaired, and language translation services are also available.</p>
<p>Cellular Phone Service Bonus SafeLink cell phone minutes for qualifying members</p>	<p>For eligible plan members who are at least 18 years of age may receive 350-500 minutes, plus unlimited text messages. The member must opt into receipt of no-cost health-oriented text message receipt from health plan. Pregnant members are encouraged to sign up for and opt into no-cost pregnancy education text messages during pregnancy. With the SafeLink phone, pregnant members can sign up for Text4Baby to receive these educational messages.</p>
<p>Condition Care Programs</p>	<p>Condition care programs and Case Managers to help members manage conditions like:</p> <ul style="list-style-type: none"> • Asthma • Bipolar disorder • Chronic obstructive pulmonary disease • Congestive heart failure • Coronary artery disease • Diabetes • HIV/AIDS • Hypertension • Major depressive disorder – adult • Major depressive disorder - child/adolescent • Schizophrenia • Substance use disorder
<p>Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/Health Check Services</p>	<p>The intent of the EPSDT program is to focus attention on early prevention and treatment. Requirements include periodic screening, vision, dental and hearing services.</p> <p>Services include:</p> <ul style="list-style-type: none"> • Screening • Diagnosis and treatment • Transportation and scheduling assistance <p>Screening must include:</p> <ul style="list-style-type: none"> • Comprehensive health and developmental history – both physical and mental health development • Comprehensive unclothed physical exam • Appropriate immunizations

Covered Special Services	Description and Coverage Limits
<p>Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/ Health Check Services, continued</p>	<ul style="list-style-type: none"> • Nutrition and activity assessment • Laboratory tests • Lead toxicity screening • Health education and anticipatory guidance • Sexually transmitted disease screening • Vision services • Dental services • Hearing services • Other necessary healthcare — diagnostic services and treatment to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services <p>Schedules used to determine when services are due:</p> <ul style="list-style-type: none"> • Bright Futures/American Academy of Pediatrics (AAP) Recommendations for Preventative Pediatric Healthcare • CDC Advisory Committee on Immunization Practices (ACIP) immunization recommendations schedule <p>EPSDT Program supports the individual state plans:</p> <ul style="list-style-type: none"> • Provide a data repository to house the EPSDT data • Mail annual preventive care recommendations to members • Mail reminders to members to make an appointment <p>The Anthem EPSDT program includes additional member outreach activities and case management, as well as a provider pre-service report.</p> <p>Special Services For members under 21 years of age, EPSDT provides any diagnosis/treatment indicated as medically necessary on an EPSDT health assessment (or any other encounter with a licensed or certified healthcare professional), even if the service is not covered by the Kentucky Medicaid program. Services not otherwise covered by the Kentucky Medicaid Program are called EPSDT Special Services.</p>

Covered Special Services	Description and Coverage Limits
<p>Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/ Health Check Services, continued</p>	<p>Anthem will cover the EPSDT Special Services below (including healthcare, diagnostic services, preventive services, rehabilitative services, treatment and other measures) to all members under the age of 21, as required by 42 USC Section 1396 and by 907 KAR 1:034, Section 7 and Section 8:</p> <ul style="list-style-type: none"> • Inpatient hospital services • Outpatient services; rural health clinics; federally qualified health center services • Other laboratory and X-ray services • EPSDT services; family planning services and supplies • Physician services; medical and surgical services furnished by a dentist • Medical care by other licensed practitioners • Home healthcare services • Private duty nursing services • Clinic services • Dental services • Physical therapy and related services • Prescribed drugs (including mental/behavioral health drugs), dentures, prosthetic devices and eyeglasses • Other diagnostic, screening, preventive and rehabilitative services • Nurse-midwife services • Hospice care • Case management services • Respiratory care services • Services provided by a certified pediatric nurse practitioner or certified family nurse practitioner (to the extent permitted under state law) • Other medical and remedial care specified by the secretary • Other medical or remedial care recognized by the secretary, not covered in the plan (including services of Christian science nurses, care and services provided in Christian science sanitariums and personal care services in a recipient’s home) <p>Those EPSDT diagnosis and treatment services and EPSDT Special Services which are not otherwise covered by the Kentucky Medicaid Program shall be covered subject to the Anthem prior authorization process, as specified in 907 KAR 1:034, Section 9. Request approvals for EPSDT Special Services will be based on the <i>Standard of Medical Necessity</i> (907 KAR 1:034, Section 9).</p> <p>Anthem will be responsible for identifying providers who can deliver the EPSDT Special Services needed by Anthem members less than 21 years of age and for enrolling these providers into Anthem’s network, consistent with contract requirements.</p>

Covered Special Services	Description and Coverage Limits
Healthy Families (Child Nutrition Support Program)	This program is offered to families with children ages 7-17 and provides coaching and support related to health goals for nutrition and activity.
Women’s Health Services – Prenatal Services	<p>Prenatal Care Services The <i>New Baby, New Life</i>SM program offers an array of services to pregnant members and newborns, to provide the best opportunity to improve birth and neonate outcomes. Every identified member receives a pregnancy mailing that directs the member to the Anthem website, where they can find information on perinatal health, the importance of prenatal and postpartum visits, and incentives for attending perinatal appointments. Members can also download the Pregnancy and Beyond Resource Guide on the Anthem website and use this guide throughout their perinatal period.</p> <p>The Kentucky Health Access Nurturing Development Services (HANDS) will make a home visit to introduce parenting skill development in areas such as recognizing your baby’s needs, what to expect as your baby grows and making your home safe, etc.</p> <p>Members can be referred to our high risk OB Case Management Program by emailing the referral form (located on the provider website under Patient Care/Pregnancy and Maternal Child Services) to kentuckycm@anthem.com</p>
Women’s Health Services – Post Services	The Kentucky Health Access Nurturing Development Services (HANDS) will make a home visit to introduce parenting skill development in areas such as recognizing your baby’s needs, what to expect as your baby grows and making your home safe, etc.

6.5 Blood Lead Screenings

Anthem is not required to use the Lead Toxicity Screening Risk Factor Questionnaire and should use clinical judgment when screening for lead toxicity. However, in order to comply with federal government requirements, the provider must perform a blood lead test at 12 months and 24 months of age to determine lead exposure and toxicity. The provider should also give blood screening lead tests to children older than 24 months up to 72 months if the provider has no past record of a test. The results of the lead screening must be included and maintained within the child’s medical record.

6.6 Immunizations

The Vaccines for Children (VFC) program helps families by providing free vaccines to doctors who serve eligible children. The program is administered nationally through the Centers for Disease Control and Prevention (CDC) National Immunization Program which contracts with vaccine manufacturers to buy vaccines at reduced rates. Providers are encouraged to enroll in the VFC program by calling **502-564-4478**.

Once enrolled, the provider may request state-supplied vaccines for members through the age of 18 in accordance with the current American Committee on Immunization Practices schedule. The provider must report all immunizations of children up to age two to the State Health Division's Immunization Registry. If the provider does not have the capability to meet these requirements, Anthem can help.

Anthem does not cover any immunizations, biological products or other products that are available free of charge from the State Health Division.

Anthem members can self-refer to any qualified provider in or out of Anthem's network, including the local health departments, for the administration of vaccines.

Anthem covers vaccines for children and adults consistent with the Department for Medicaid Services. For children specifically, there are two categories:

- VFC (for members through the age of 18): The administration and vaccine codes should be billed. The SL modifier should be billed with the vaccine code to signify a VFC-covered vaccine. Reimbursement will be for the administration of the vaccine only.
- Non-VFC: The administration and vaccine codes should be billed. Reimbursement will be for both codes.

All immunizations administered to members must be kept up to date and maintained within the medical record of that member.

6.7 Medically Necessary Services

Medically necessary is a term used to describe a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in a patient that:

- Endanger life
- Cause suffering or pain
- Result in an illness or infirmity
- Threaten to cause or aggravate a handicap
- Cause physical deformity or malfunction

Anthem takes into consideration whether there is another equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purposes of this section, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all. The amount and duration of services that are medically necessary depend on each member's medical condition.

Anthem does not reward practitioners or other individuals for issuing denials of coverage or care, and financial incentives for utilization management decision-makers do not encourage decisions that result in underutilization.

A covered service is considered to be medically necessary if it is recommended by the member's treating provider and the Anthem medical director or provider designee and if all of the following conditions are met:

- The purpose of the service, supply or intervention is to treat a medical condition.

- It is the most appropriate level of service, supply or intervention considering the potential benefits and harm to the patient.
- The level of service, supply or intervention is known to be effective in improving health outcomes.
- The level of service, supply or intervention recommended for the condition is cost-effective compared to alternative interventions, including no intervention.
- For new interventions, effectiveness is determined by scientific evidence; for existing interventions, effectiveness is determined, first, by scientific evidence, then by professional standards, then by expert opinion.
- The service is not cosmetic, experimental or investigational and is not a contractual exclusion of the member's benefits.

Anthem is responsible for covering medically necessary services related to:

- Prevention, diagnosis and treatment of health impairments
- Achievement of age-appropriate growth and development
- The attainment, maintenance or regaining of functional capacity
- Anthem will notify and obtain approval from the Department for Medicaid Services for any new services prior to implementation.

6.8 Pharmacy Services

The Anthem pharmacy benefit provides coverage for medically necessary medications from licensed prescribers for the purpose of saving lives in emergency situations or during short-term illnesses, sustaining life in chronic or long-term illnesses, or limiting the need for hospitalizations. Members have access to most national pharmacy chains and many independent retail pharmacies.

Pharmacy providers are responsible for, but not limited to, the following:

- Filling prescriptions in accordance with the benefit design
- Coordinating with licensed prescribers
- Ensuring members receive all medications for which the members are eligible
- Coordinating benefits when members also receive Medicare Part D services or other insurance benefits
- Providing emergency supplies of prescribed medications any time prior authorizations are not available, if the prescribing providers cannot be reached or are unable to request prior authorizations, and when prescriptions must be filled without delay for medical conditions; these supplies will be provided for as long as is sufficient to bridge the time until an authorization determination is made

Anthem contracts with MedImpact as a Pharmacy Benefit Manager (PBM) to process pharmacy claims using a computerized point-of-sale system. This system gives participating pharmacies online, real-time access to beneficiary eligibility; drug coverage, including prior authorization requirements; prescription limitations; pricing and payment information; and prospective drug utilization review. The MedImpact call center number is **844-336-2676** and is staffed seven (7) days a week, 8 a.m. to 7 p.m. ET.

6.8.1 Covered Drugs

The Anthem Pharmacy Program utilizes the DMS Preferred Drug List (PDL), which is a list of the preferred drugs within the most commonly prescribed therapeutic categories. The formulary includes all

therapeutic classes in the DMS fee-for-service drug file and a sufficient variety of drugs in each therapeutic class to meet member's medically necessary healthcare needs. This preferred drug list is made available to pharmacy providers and members via posting on the web and other relevant means of communication. Formulary over-the-counter products are covered when ordered by a licensed prescriber.

For Pharmacy Retail, to prescribe non-preferred drugs or other medications that require prior authorization, call MedImpact at 844-336-2676.

The following are examples of covered items:

- Legend drugs
- Insulin
- Disposable insulin needles/syringes
- Disposable blood/urine glucose/acetone testing agents
- Lancets and lancet devices
- Compounded medication of which at least one ingredient is a legend drug and listed on the Kentucky Medicaid PDL
- Any other non-excluded drug, which under the applicable state law, may only be dispensed upon the written prescription of a physician or other lawful prescriber and is listed on the Kentucky Medicaid PDL

6.8.2 Obtaining Prior Authorizations

Providers are strongly encouraged to write prescriptions for preferred products as listed on the formulary or PDL. **If for medical reasons members cannot use preferred products, providers are required to call MedImpact at 844-336-2676 or fax a request to 858-357-2612 for Retail Pharmacy.**

For Medical Injectables, call Anthem at 855-661-2028 or fax 844-487-9289 to receive prior authorizations. Be prepared to provide relevant clinical information regarding the member's need for a non-preferred product or a medication requiring prior authorization.

Decisions are based on medical necessity and are determined according to certain established medical criteria. Only the prescribing providers or one of the provider's staff representatives can request prior authorizations.

Examples of medications that require prior authorizations are listed below. This list is not all-inclusive and is subject to change:

- Drugs listed on the formulary or PDL or drugs that require clinical prior authorizations
- Drugs not listed on the formulary
- Certain self-administered injectable products
 - Drugs that exceed certain cost and/or dosing limits

An emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization is not available. This applies to all drugs requiring prior authorization, either because the drugs are non-preferred drugs on the PDL or because the drugs are subject to clinical edits.

The emergency supply should be dispensed anytime a prior authorization cannot be resolved within 24 hours for a medication that is appropriate for the member's medical condition. If the prescribing

provider cannot be reached or is unable to request a prior authorization, the pharmacy should provide an emergency 72-hour supply.

A pharmacy can dispense a product packaged in dosage form that is fixed and unbreakable (for example, an albuterol inhaler) as an emergency supply.

6.8.3 Dispensing Limitations

Several drugs have dispensing limitations to ensure appropriate use. Refer to the formulary PDL to identify drugs subject to these restrictions.

6.8.4 Excluded Drugs

The following drugs are excluded from the pharmacy benefit:

- Drug products that are classified as less-than-effective by the FDA Drug Efficacy Study Implementation
- Drugs excluded from coverage following Section 1927 of the *Social Security Act*, 42 U.S.C.A. §1396r-8 such as:
 - Weight control products, excluding Alli, which requires prior authorization
 - Drugs used for cosmetic reasons or hair growth
 - Experimental or investigational drugs
 - Drugs used for experimental or investigational indication
 - Infertility medications
 - Erectile dysfunction drugs to treat impotence
- Non-legend drugs other than those listed above or specifically listed under covered non-legend drugs
- Pharmaceutical products prescribed by any providers related to services provided under separate contracts with the DMS

Chapter 7: Behavioral Health Integrated Services

7.1 Overview of Anthem's Behavioral Health Program

The mission of Anthem is to coordinate the physical and behavioral health care of members, offering a continuum of targeted interventions, education and enhanced access to care to improve outcomes and quality of life for members. Anthem works collaboratively with a wide range of behavioral health care providers, community agencies and resources to successfully meet the needs of members with Mental Health (MH), Substance Abuse (SA) and Intellectual Disabilities/Developmental Disabilities (ID/DD). Anthem and its providers will comply with the Mental Health Parity and Addiction Equity Act of 2008 and 42 C.F.R. 438 Subpart K, including the requirements that treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by Anthem and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

7.2 Program Goals

The goals of the Anthem Behavioral Health (BH) program are to:

- Ensure accessibility to available services for eligible members
- Expand adequacy of service availability
- Ensure utilization of the most appropriate, least restrictive, medical and behavioral health care in the right place at the right time
- Promote integration of the management and delivery of physical and behavioral health services to members
- Achieve quality initiatives including those related to HEDIS[®], NCQA and Kentucky's Cabinet for Health and Family Services performance requirements
- Work with members, providers and community supports to provide recovery tools and create an environment that supports members' progress towards recovery goals.

7.3 Program Objectives

The objectives of the Anthem BH program are to:

- Work with care providers to ensure the provision of medically necessary and appropriate care and services to Anthem members at the least restrictive level of care, including inpatient care, alternative care settings and outpatient care, both in-and out-of-network;
- Provide member education on treatment options and pathways towards recovery;
- Provide high quality case management and care coordination services designed to identify member needs and address them in a person-centered, holistic manner;
- Promote continuity and coordination of care among physical and behavioral health care practitioners;
- Maintain compliance with local, state and federal requirements, as well as accreditation standards;
- Utilize evidence-based guidelines and clinical criteria when determining treatment;
- As a best practice, promote the use of same in the provider community;

- Enhance member satisfaction by working with members in need to implement an individually tailored and holistic support and care plan that allows the member to succeed at achieving his/her recovery goals;
- Enhance provider satisfaction and provider success by working to develop collaborative and supportive provider relationships built on mutually agreed upon goals, outcomes and incentives;
- Promote all healthcare partners to work together to achieve quality and recovery goals through education, technological supports and the promotion of recovery ideals;

Anthem contracted providers deliver behavioral health and substance use disorder services in accordance with best practice guidelines, rules and regulations, and policies and procedures set forth by Kentucky.

7.4 Treatment Guidelines

7.4.1 Recovery & Resiliency

Anthem believes physical and behavioral health services should be rendered in a manner that supports the recovery of persons experiencing mental illness and enhances the development of resiliency of those who are impacted by mental illness, serious emotional disturbance and/or substance use disorder issues. Recovery is a consumer-driven process in which consumers find paths to work learn and participate fully in the member’s communities. Recovery is the ability to live a fulfilling and productive life despite the continued presence of a disability. Resiliency is the learned ability to cope and adapt positively to the challenges and change brought on by distress, disability or adverse circumstances.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has released a consensus statement on mental health recovery. The components listed in this consensus statement are reflective of the desire that all behavioral health services be delivered in a manner that promotes individual recovery and builds resiliency. The ten fundamental components of recovery as explained by SAMHSA include:

- a. **Self-direction:** Consumers lead, control, exercise choice over and determine the individual path of recovery by optimizing autonomy, independence and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.
- b. **Individualized and person-centered:** There are multiple pathways to recovery based on an individual’s unique strengths and resiliency, as well as his or her needs, preferences, experiences (including past trauma) and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result, as well as an overall paradigm for achieving wellness and optimal mental health.
- c. **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions — including the allocation of resources — that will affect consumers’ lives and are educated and supported in so doing. Consumers have the ability to join with other consumers to collectively and effectively speak for themselves about consumer needs, wants, desires and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.
- d. **Holistic:** Recovery encompasses an individual’s whole life, including mind, body, spirit and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services

(for example, recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation and family supports as determined by the person. Families, providers, organizations, systems, communities and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

- e. Nonlinear: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.
- f. Strengths-based: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (for example, partner, caregiver, friend, student and employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
- g. Peer support: Mutual support — including the sharing of experiential knowledge and skills and social learning — plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles and community.
- h. Respect: Community, systems and societal acceptance and appreciation of consumers — including protecting consumer rights and eliminating discrimination and stigma — are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of consumer lives.
- i. Responsibility: Consumers have a personal responsibility for individual self-care and journeys of recovery. Taking steps towards goals may require great courage. Consumers must strive to understand and give meaning to experiences and identify coping strategies and healing processes to promote own wellness.
- j. Hope: Recovery provides the essential and motivating message of a better future — that people can and do overcome the barriers and obstacles that confront them. Hope is internalized but can be fostered by peers, families, friends, providers and others. Hope is the catalyst of the recovery process.

7.4.2. Systems of Care

Services that are provided to children and youth with serious emotional disturbances and those children's families are best delivered based on the System of Care Values and Principles that are endorsed by the SAMHSA and the Center for Mental Health Services (CMHS). Services should be:

- Child-centered and family focused with the needs of the child and family dictating the types and mix of services provided
- Community-based with the focus of services as well as management and decision making responsibility resting at the community level
- Culturally competent with agencies, programs and services that are responsive to the cultural, racial and ethnic differences of the populations served
- The guiding principles of a system of care should include the following. Children should:
 - Have access to a comprehensive array of services that address the child's physical, emotional, social, educational and cultural needs

- Receive individualized services in accordance with unique needs and potential, which is guided by an individualized service plan
- Receive services within the least restrictive, most normative environment that is clinically appropriate
- Receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing and coordinating services
- Be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated, therapeutic manner and adapted in accordance with the changing needs of the child and family
- Receive services without regard to race, religion, national origin, sex, physical disability or other characteristics

7.4.3. Recovery Oriented Systems of Care

Recovery Oriented Systems of Care for adolescents and adults provide independent free choice among an array of treatment and recovery support options. Services are flexible and evolve over time to meet the changing needs of the recovering individual. The services are coordinated to support each individual's unique recovery path. A recovery oriented system of care is as complex and dynamic as the process of recovery.

7.5 General Provider Information

Anthem believes the success of providers is necessary to achieve Anthem's goals. Anthem is committed to supporting and working with qualified providers to ensure that Anthem jointly meets quality and recovery goals. Such commitment also includes:

- Improving communication of the clinical aspects of behavioral health care to improve outcomes and recovery.
- Supporting providers in delivering integrated, coordinated physical and behavioral health services to meet the needs of the whole person.
- Precertification rules, claims and payment processes to help providers reduce administrative time and focus on the needs of members.
- Using reasonable precertification requirements that minimize administrative burden.

On the Anthem provider website (providers.anthem.com/ky), you can find:

- Mental health and substance use covered services.

The following is an outline, but not limited to, behavioral health and substance abuse services:

- Inpatient
- Detoxification
- Crisis Intervention
- Mobile crisis services
- Individual, group, family and collateral therapies
- Peer support services
- Intensive outpatient program services
- Service planning
- Partial hospitalization
- Assertive Community Treatment
- Targeted case management

- Applied Behavioral Analysis
- Comprehensive Community Support Services
- Therapeutic Rehabilitation Program
- Psychiatric Residential Treatment
- Residential Substance Use Disorder
- Psychological Testing
- Screening, Brief Intervention, & Referral for Treatment (SBIRT)
- Smoking & Tobacco Use Cessation Counseling

The behavioral health benefit does not typically cover disorders of sleep, pain, language and other behavioral/psychological conditions with organic causes. These disorders may be covered under the medical benefit if provided by physicians or nurse practitioners. If providers have questions regarding a covered diagnosis, please contact Anthem’s customer service center.

All service locations must meet the requirements of the Americans with Disabilities Act, Commonwealth and local requirements pertaining to adequate space, supplies, sanitation, and fire and safety procedures applicable to healthcare facilities. Anthem shall cooperate with the Cabinet for Health and Family Services’ independent ombudsman program, including providing immediate access to a member’s records when written member consent is provided.

7.6 Screening, Brief Intervention and Referral to Treatment (SBIRT)

Anthem adopted SBIRT (Screening, Brief Intervention and Referral to Treatment), which is a comprehensive, integrated approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders.

SBIRT is an assessment tool used to identify and reduce ongoing use, dependency and abuse of alcohol and other substances in a primary care setting. The screening will provide opportunities for early intervention with at-risk alcohol and other substance abuse.

All eligible members will be required to have an annual SBIRT screening by their assigned primary care physician. An SBIRT can be assessed by a primary care physician, nurse practitioner or a physician assistant who has completed SBIRT training. Screening is recommended beginning at age 9.

SBIRT practice:

- Screening — identifies the appropriate level of treatment and the severity of substance use.
- Brief intervention— focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Recommendations for additional care and treatment — provides those identified as needing more extensive treatment with access to specialty care.

7.7 Member Records and Treatment Planning

Member records must meet the following standards and contain the following elements, if applicable, to permit effective service provision and quality reviews:

- Information related to the provision of appropriate services to a member must be included in his or her record to include documentation in a prominent place whether there is an executed declaration for mental health treatment.
- For members receiving behavioral health services, a comprehensive assessment of the member's physical and mental health status at the time of admission to services may be required. This comprehensive assessment will cover:
 - **A psychiatric and psychosocial assessment that includes:**
 - Description of the presenting problem
 - Psychiatric history and history of the member's response to crisis situations
 - Psychiatric symptoms
 - Multi-axial diagnosis using the most current edition of Diagnostic and Statistical Manual of Mental Disorders (DSM)
 - Mental status exam
 - **A medical assessment that includes:**
 - Screening for medical problems
 - Medical history
 - Present medications
 - Medication history
 - **A substance use assessment that includes:**
 - Frequently used over-the-counter medications
 - Current and historical usage of alcohol and other drugs reflecting impact of substance use in the domains of the community functioning assessment
 - History of prior alcohol and drug treatment episodes and treatment effectiveness
 - **A community functioning assessment or an assessment of the member's functioning in the following domains:**
 - Living arrangements, daily activities (vocational/educational)
 - Social support
 - Financial
 - Legal
 - Leisure/recreational
 - Physical health
 - Emotional/behavioral health
 - An assessment of the member's strengths, current life status, personal goals and needs
- A patient-centered treatment plan, which is based on the psychiatric, medical, substance use and community functioning assessments listed above, must be completed for any member who receives behavioral health services.
- The treatment 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 towards goals or a significant change in psychiatric symptoms, medical condition and/or community functioning.
- There must be documentation in every case that the member and, as appropriate, their family members, caregivers, or legal guardian, participated in the development and subsequent reviews of the treatment plan.
- The treatment 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 that 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 towards 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
- 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 recommendations for additional care to appropriate medical or social support professionals have been made.
- If the provider uncovers a gap in care, it is the provider's responsibility to help the member get that gap in care fulfilled. Documentation should reflect the provider's action in this regard.
- For providers of multiple services, one comprehensive treatment 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.
- Progress notes are written to document status related to goals and objectives indicated on the treatment plans and should include:
 - Correspondence concerning the member's treatment and signed and dated notations of telephone calls concerning the member's treatment
 - Documentation of follow up actions for recommendations for additional care given to the member and actions to fill gaps in care
- A brief discharge summary must be completed within 15 calendar days following discharge from services or death summarizing progress made while in treatment; ongoing treatment concerns; current state of psychiatric symptoms, medical condition and/or community functioning; and aftercare plan including recommendations for additional ongoing care.
- Providers must contact members who have missed appointments within 24 hours to reschedule those appointments and document such efforts in the member's medical record. Providers should assess barriers to follow-up at this time.
- Medical records, treatment plans and progress notes should be signed by the supervising physician.

7.8 Community Provider Requirements

7.8.1 Community Mental Health Clinics

Behavioral Health service providers must assign a case manager prior to or on the date of discharge and provide case management services to members with severe mental illness and co-occurring developmental disabilities who are discharged from a state-operated or state-contracted psychiatric facility or state-operated nursing facilities for members with severe mental illness. The case manager, and other identified behavioral health service providers shall participate in discharge planning meetings to ensure compliance with federal Olmstead and other applicable laws. Appropriate discharge planning shall be focused on ensuring needed supports and services are available in the least restrictive environment to meet the member's behavioral and physical health needs, including psychosocial

rehabilitation and health promotion. Appropriate follow-up by the behavioral health service provider shall occur to ensure community supports are meeting the needs of the member discharged from a state-operated or state-contracted psychiatric hospital.

7.8.2 Federally Qualified Health Centers and Rural Health Clinics

To the extent that non-psychiatrists and other providers of Behavioral Health services may also be provided as a component of Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services, these facilities are offered the opportunity to participate in the health plan's Behavioral Health network. FQHC and RHC providers can continue to provide the same services the provider currently provides under licensure.

7.9 Psychotropic Medications

Prescribing providers must inform all members being considered for prescription of psychotropic medications of the benefits, risks and side effects of the medication, alternate medications and other forms of treatment.

Members taking psychotropic medications may be at increased risk for various disorders. As such it is expected that providers are knowledgeable about side-effects and risks of medications and regularly inquire about and seek for any side-effects from medications. This especially includes:

1. Follow-up to inquire about suicidality or self-harm in children placed on anti-depressant medications as per Food and Drug Administration and American Psychiatric Association guidelines
2. Regular and frequent weight checks and measurement of abdominal girth especially for those on antipsychotics or mood stabilizers
3. Glucose tolerance test or hemoglobin A-1C tests especially for those members on antipsychotics or mood stabilizers
4. Triglyceride and cholesterol checks especially for those members on antipsychotics and mood stabilizers
5. ECG checks for members placed on medications with risk for significant QT-prolongation
6. Ongoing checks for movement disorders related to antipsychotic use and psychotic disorders

Guidelines for such testing and follow-up are provided by the American Psychiatric Association amongst others. Summary guidelines are referenced in Anthem's Clinical Practice Guidelines (CPGs) which can be found at providers.anthem.com/ky. While the prescriber is not expected to personally conduct all of these tests; the prescriber is expected to ensure that these tests occur where indicated and to initiate appropriate interventions to address any adverse results. These tests and interventions are expected to be documented in the medical record for the member.

Behavioral health service providers should assist members in accessing free or discounted medication through the Kentucky 130 Prescription Assistance Program (KPAP) or other similar assistance programs.

7.10 Utilization Management Decision Making

Anthem's utilization management (UM) decisions are governed by the following statements:

- UM-decision making is based only on appropriateness of care and service and existence of coverage.

- Anthem does not specifically reward practitioners or other individuals for issuing denials of covered services. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that Anthem supports, or tend to support denial of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization, or create barriers to care and service.
- Anthem behavioral health utilization managers currently follow MCG for medical necessity criteria, except for substance use services, which use criteria from the American Society of Addiction Medicine (ASAM). If MCG does not cover a behavioral health service, the following standardized tools for medical necessity determinations will be used:
 - a. Adults: Level of Care Utilization System® (LOCUS)
 - b. Children and adolescents: Child and Adolescent Service Intensity Instrument (CASII)
 - c. Young children: Early Childhood Service Intensity Instrument (ECSII)

7.10.1 Timeliness of Decisions on Requests for Authorization

Behavioral Health	<ol style="list-style-type: none"> 1. Urgent, Preservice Requests: 2 business days 2. Urgent Concurrent Requests: 1 calendar day 3. Routine, Non-urgent requests: 2 business days 4. Retrospective Review Requests: Within 14 calendar days
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7.10.2 Responsibilities of Behavioral Health Providers — Behavioral Health Access to Care Standards

This grid outlines standards for timely and appropriate access to quality behavioral health care:

Behavioral Health	<ol style="list-style-type: none"> 1. Emergent: Immediately 2. Emergent, Non-Life-Threatening/Crisis Stabilization; Within 24 hours of request 3. Urgent: Within 48 hours of referral/request 4. Outpatient treatment by a BH provider post-inpatient discharge: seven calendar days 5. BH providers must contact members who have missed an appointment within 24 hours to reschedule appointments
Definitions	<p><i>Emergent:</i> 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 members are either unsafe or individual conditions are deteriorating.</p> <p><i>Urgent:</i> Means a service need that 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 abuse problems she is to be placed in the urgent category.</p> <p><i>Routine:</i> Means a service need that is not urgent and can be met by receiving and treatment within 10 calendar days of the assessment without resultant deterioration in the individual's functioning or worsening of his or her condition.</p>

Emergency Care as defined in 42 USC 1395dd and 42 C.F.R. 438.114 is available to members 24 hours a day, seven (7) days a week. Urgent Care services will be made available within 48 hours of request. Urgent Care means care for a condition that is not likely to cause death or lasting harm but for which

treatment should not wait for a normally scheduled appointment. Post Stabilization Care services are covered and reimbursed in accordance with 42 C.F.R. 422.113(c) and 438.114(e).

Anthem must cover inpatient psychiatric services to members under the age of 21 and over the age of 65 who have been ordered to receive the services by a court of competent jurisdiction under the provisions of KRS 645, Kentucky Mental Health Act of The Unified Juvenile Code and KRS 202A, Kentucky Mental Health Hospitalization Act. Anthem cannot deny, reduce or controvert the medical necessity of inpatient psychiatric services provided pursuant to a Court-Ordered Commitment for members under age 21 or over age 65. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.

Anthem will consider level system interventions if low rates persist, such as dissemination of appropriate time frames to providers, discharge planning prior to discharge and assessment of needs prior to discharge.

As part of Anthem's commitment to providing the best quality provider networks for Anthem members, Anthem conducts annual telephonic surveys to verify provider appointment availability, provider hours of operation and after-hours access. Providers will be asked to participate in this survey each year.

The Anthem Behavioral Health Crisis Hotline (**855-661-2025**) is available 24 hours a day, seven days a week and 365 days a year for life-threatening behavioral health member emergencies.

Anthem's Clinical Staff

Anthem has assembled a highly trained and experienced team of clinical care managers, case managers and support staff to provide high quality care management and care coordination services to Anthem members and to work collaboratively with Anthem's providers. All clinical staff is licensed and has experience requirements which generally include at least four years of prior clinical experience. Anthem's BH Medical Director is board certified in psychiatry and licensed in Kentucky.

How to Provide Notification or Request Precertification

Providers may request precertification for outpatient mental health services that require precertification via phone by calling **855-661-2028**. Please be prepared to provide clinical information and the member's current treatment plan in support of the request at the time of the call.

- Providers may request precertification via fax or via Availity Essentials [Availity.com](https://www.availity.com) (Select Patient Registration > Authorizations & Referrals) for certain levels of care. Kentucky approved fax forms can be obtained on Anthem's provider website at providers.anthem.com/ky. The Anthem behavioral health fax number is:
 - Outpatient requests: **866-877-5229**
 - Inpatient requests: **877-434-7578**
- All requests for precertification for psychological and neuropsychological testing should be submitted via fax at **866-877-5229** (See Provider Forms section). Psychological/neurological testing request forms can also be mailed to:
 - Behavioral Health Department
 - Anthem
 - P.O. Box 62509
 - Virginia Beach, VA 23466-2509

Behavioral Health Medical Necessity Determination and Peer Review

- When a provider requests initial or continued precertification for a covered behavioral health service, Anthem’s utilization managers obtain necessary clinical information including the member’s current treatment plan and review it to determine if the request appears to meet applicable medical necessity criteria.
- If the provider is not able to provide a current treatment plan as detailed in section 7.7 of this manual, the utilization manager may issue a medical necessity denial as appropriate for the service due to insufficient documentation to make a clinical decision.
- If the information submitted does not appear to meet such criteria, the utilization manager submits the information for review by a Kentucky behavioral health 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 within seven calendar days of the decision. In this case, Anthem will make a behavioral health 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. A peer-to-peer is not considered to be an appeal and does not limit subsequent appeal rights. The peer-to-peer process does not affect the appeal time frame.
- Members, requesting 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.

Non-Medical Necessity Adverse Decisions (Administrative Adverse Decision)

If a provider receives an Administrative Adverse Determination and thinks this decision was in error, please see the sections within this provider manual that contain 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 the provider and staff with notification and precertification policies and acting to meet those policies can eliminate the majority of these decisions. Other administrative adverse decisions may result from insufficient documentation being provided, misinformation about the member’s status or the member’s 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. Anthem is committed to working with all providers to ensure that such guidelines are understood and to identify gaps for providers around meeting such guidelines. 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 and to provide a one-on-one communication about the guidelines, as necessary. Medical record reviews are another way to ensure clinical information is complete and accurate. Providers who are able to appropriately respond in a timely fashion to peer-peer and medical record requests are less likely to encounter dissatisfaction with the utilization management process. Anthem is committed to ensuring a process that is quick and easy and will work with participating providers to ensure a mutually satisfying process where possible.

A provider can appeal an administrative denial (for untimely notification of inpatient admissions or for untimely submission of clinical information). An administrative appeal must be filed within 60 calendar days of the postmark date of Anthem's denial notification.

7.10.3 Coordination of Behavioral Health and Physical Health Treatment

Anthem coordinates the delivery of medically necessary behavioral health services through two distinct service components:

1. Primary Behavioral Health Services may be delivered by network providers other than BH specialty providers including:
 - a. Clinical evaluation and assessment of needed behavioral health services and the provision of primary behavioral health services or recommendations for additional services, as appropriate.
 - b. The primary care provider (PCP) may elect to treat the member, regardless of the diagnosis, if the treatment falls within the scope of the PCP practice, training and expertise.
 - c. When, in the PCP's judgment, a member's need for behavioral health treatment cannot be adequately addressed by primary behavioral health services provided by the PCP, the PCP refers the member to the Specialty Behavioral Health Services
2. Specialty Behavioral Health Services delivered by a contracted Behavioral Health specialist provider.

Anthem staff assist members in accessing behavioral health services on request through a referral to a Behavioral Health provider in Anthem's provider network.

Anthem staff assist providers in those instances where a member exhibits behavior in the provider's office which warrants intervention by a behavioral health professional.

A member may self-refer to participating providers for behavioral health services.

It is estimated approximately 80% of the members in care have comorbid conditions. Anthem puts special emphasis on the coordination and integration of physical and behavioral health services, wherever possible. Cooperation and collaboration among all treating providers will positively enhance outcomes and ensure patient safety and well-being. Anthem's program requires open communication between PCPs and behavioral health providers when a member's condition or medications change. Key provider elements of the coordinated care model include:

- Ongoing communication and coordination between PCPs and specialty providers, including behavioral health (mental health and substance use) providers.
- Screening for co-occurring disorders, including:
 - Behavioral health screening by PCPs, including SBIRT
 - Medical screening by behavioral health providers
 - Screening of mental health patients for co-occurring substance use disorders
 - Screening of consumers in substance use disorder treatment for co-occurring mental health and/or medical disorders and/or any known or suspected and untreated physical health disorders
 - Screening tools for PCPs and behavioral health providers can be located at providers.anthem.com/ky.
 - Such screening and evaluation procedures shall be submitted to the Department for Medicaid Services, Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) for approval.

- Recommendations for additional care to PCPs or specialty providers, including behavioral health providers, for assessment and/or treatment for consumers with co-occurring disorders and/or any known or suspected and untreated physical health disorders.
- Involving members, as well as caregivers and family members, as appropriate, in the development of patient-centered treatment plans.
- Case management and condition care programs to support the coordination and integration of care between providers.
- Anthem's standard is that physical and behavioral health providers share relevant case information at the following junctures in care:
 1. The member enters physical or behavioral health care;
 2. There is a significant change in the members condition or treatment plan for either physical or behavioral health care;
 3. Upon admission to, discharge from, the hospital for either physical or behavioral health care;
 4. When coordination is otherwise warranted.
- Sharing of information between physical and behavioral health providers for the purpose of coordination of care does not require member consent unless required by applicable state law or other regulatory requirement with the exception of the release of substance abuse treatment records, which requires the member's authorization under 42 USC 290 - Sec. 290dd-2. Confidentiality of Records. It is the coordinating provider's responsibility to ensure that any disclosure of Personal Health Information (PHI) conforms to *HIPAA* privacy and other applicable regulations.
- Wherever possible, Anthem facilitates the sharing of relevant case information between primary care and behavioral health providers.
- Maintenance of documentation of care coordination by Anthem staff can be found in the member's medical record in the Care Management system.
- When a provider recognizes a co-occurring health or behavioral health need requiring assessment and/or treatment outside the provider's scope of treatment, the provider may utilize the Provider Line for consultation and/or assistance with referrals.
- To encourage coordination between providers, behavioral health providers have access to a coordination form to alert physical health practitioners when a member enters treatment. Providers can access the form on the provider website.
- Upon hospitalization for members having co-occurring physical and behavioral health conditions, the primary diagnosis determines who would be the primary provider and location of service. In such cases, the primary provider is responsible for ensuring coordination of care for both physical and behavioral health conditions. Based on the clinical situation and the needs of the member, concurrent treatment of both physical and behavioral health conditions is encouraged.
- When there are co-occurring physical and behavioral health conditions, appropriate clinical staff collaborate with providers to ensure coordination of all necessary care is based on the needs of the member. Behavioral health service providers shall refer members with known or suspected and untreated physical health problems or disorders to the member's PCP for examination and treatment, with the member's or the member's legal guardian's consent. Behavioral health providers may only provide physical healthcare services if licensed to do so.
- Anthem requires behavioral health providers to send initial and quarterly (or more frequently if clinically indicated) summary reports of a members' behavioral health status to the PCP, with the member's or the member's legal guardian's consent.

- The minimum elements to be included in such correspondence are:
 - Patient demographics
 - Date of initial or most recent behavioral health evaluation
 - Recommendation to see PCP, if medical condition identified or need for evaluation by a medical practitioner has been determined for the enrollee (for example, EPSDT screen, complaint of physical ailments)
 - Diagnosis and/or presenting behavioral health problem(s)
 - Prescribed medication(s)
 - Behavioral health clinician's name and contact information (See Forms Section).

Anthem will provide training to contracted PCPs on how to screen for and identify behavioral health disorders, the referral process for Behavioral Health Services and clinical coordination requirements for such services. Anthem will include training on coordination and quality of care, such as behavioral health screening techniques for PCPs and new models of behavioral health interventions.

Clinical Practice Guidelines

All providers have ready access to evidence-based clinical practice guidelines for a variety of behavioral health disorders commonly seen in primary care, including ADHD, bipolar disorder for children and adults, major depressive disorder, schizophrenia and substance abuse disorders. Please see the provider website at providers.anthem.com/ky.

Chapter 8: Precertification/Prior Notification

8.1 Confidentiality of Information during the Process

Anthem maintains procedures to help ensure patients' Protected Health Information (PHI) is kept confidential. PHI is shared only with those individuals who need access to it to conduct some or all of the following functions:

- Pharmacy
- Utilization management
- Case management
- -Chronic Condition Care
- Discharge planning
- Quality management
- Claims payment

8.2 Coverage Guidelines

Some services may require preauthorization; visit Anthem's provider self-service site for additional information and requirements prior to performing services. For the most up-to-date precertification/notification requirements go to providers.anthem.com/ky.

Precertification is required for all visits and procedures performed by nonparticipating providers.

Availity Essentials, [Availity.com](https://www.availity.com), (Select Patient Registration > Authorizations & Referrals) is the preferred method for the submission of preauthorization requests, offering a streamlined and efficient experience for providers requesting inpatient and outpatient medical or behavioral health services for Anthem members. Additionally, providers can use this tool to make inquiries on previously submitted requests regardless of how they were sent (phone, fax or **Availity**).

Initiate preauthorization requests online, eliminating the need to fax. The authorization application allows detailed text, photo images and attachments to be submitted along with your request.

- **Make inquiries** on requests previously submitted via phone, fax or ICR.
- **Instant accessibility** from almost anywhere including after business hours.
- **Utilize the dashboard** to provide a complete view of UM requests submitted by your organization with real-time status updates including email notifications if requested using a valid email address.
- **Real-time results** for some common procedures with immediate decisions.

For an optimal experience with the authorization application, use a browser that supports 128-bit encryption. This includes Microsoft Edge, Chrome, or Firefox.

Anthem has clinical staff available 24 hours a day, 7 days a week, including federal holidays, to accept precertification requests or answer questions about UM processes and/or UM issues. When a medical request is faxed, Anthem:

- Verifies member's eligibility and benefits
- Determines the appropriateness of the request

- Issues the provider a reference number

Covered Benefits
Alternative Birthing Center Services (907 KAR 1:180)
Ambulatory Surgical Care Services (907 KAR 1:008)
Behavioral Health/Substance Abuse Services
Cardiac Rehabilitation (907 KAR 3:125)
Chemotherapy
Chiropractic Services (907 KAR 3:125)
Community Mental Health Center Services (907 KAR 1:046)
Circumcision
Dental Services (907 KAR 1:026) including Oral Surgery, Orthodontics, and Prosthodontics
Dermatology
Diagnostic Testing
Durable Medical Equipment (DME) (907 KAR 1:479) including Prosthetic and Orthotic Devices, and Disposable Medical Supplies
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Screening and Special Services (907 KAR 11:034)
Educational Consultation
Emergency Room
End Stage Renal Dialysis Services
ENT Services (Otolaryngology)
Family Planning/Sexually Transmitted Infection (STI) Care (907 KAR 1:048 & 1:434)
Gastroenterology Services
Gynecology (also see Obstetrical Care)
Hearing Services, including hearing aids (907 KAR 1:038)
Home Healthcare (907 KAR 1:030)
Hospice services (non-institutional only) (907 KAR 1:330 & 1: 436)
Inpatient Hospital Services (907 KAR 10:012)
Inpatient Mental Health Services
Independent Laboratory Services (Outpatient) (907 KAR 1:028)
Meals and Lodging for Appropriate Escort of Members
Medical Detoxification, meaning management of symptoms during the acute withdrawal phase from a substance to which the individual has been addicted
Medical Services, including but not limited to, those provided by Physicians, Advanced Practice Registered Nurses, Physician Assistants and FQHCs, Primary Care Centers and Rural Health Clinics
Medical Supplies (907 KAR 1:479)
Medical Injectable
Neurology
Observation
Obstetric Care
Ophthalmology
Oral Maxillofacial
Out-of-Area/Out-of-Network Care – REQUIRES PRIOR AUTHORIZATION
Outpatient Hospital and Ambulatory Surgery
Outpatient Mental Health Centers
Pain Management/Physiatry/Physical Medicine and Rehabilitation
Pharmacy and Limited Over-the-Counter Drugs including Mental/Behavioral Health Drugs (907 KAR 1:019, KRS 205.5631, 205,5632, 205.560)
Podiatry Services (907 KAR 1:270)

Covered Benefits
Preventative Health Services (907 KAR 1:360) including those currently provided in Public Health Departments, FQHCs/Primary Care Centers, and Rural Health Clinics
Psychiatric Residential Treatment Facilities (Level I and II) (907 KAR 9:005)
Radiology
Rehabilitation Therapy (Short Term): OT, PT, RT and ST
Sleep Studies 907 KAR 3:005
Specialized Case Management Services for Members with Complex Chronic Illnesses (includes adult and child targeted case management)
Specialized Children's Services Clinics
Sterilization (42 CFR 441.250 & KRS 205.560)
Transplantation, Organ (907 KAR 1:350)not considered Investigational by FDA
Targeted Case Management (907 KAR15:005, 907 KAR 15:040 - 15:065)
Therapeutic Evaluation and Treatment, including Physical Therapy, Speech Therapy, Occupational Therapy
Transportation to Covered Services, including Emergency and Ambulance Stretcher Services (907 KAR 1:060)
Tobacco Cessation Services (907 KAR 3:215)
Urgent Care Center, Urgent and Emergency Care Services
Vision Care, including Vision Examinations, Services of Opticians, Optometrists and Ophthalmologists, including eyeglasses (907 KAR 1:632)
Well-woman Exam

Anthem does not reward practitioners, providers or employees who perform utilization reviews, including those of the delegated entities for not authorizing healthcare services. No individual is compensated or provided incentives to encourage denials, limited authorization or discontinue medically necessary covered services.

8.3 Skilled Nursing Facility

Anthem is responsible for ancillary, physician and pharmaceutical charges. The Department for Medicaid Services will reimburse for those services billed by the nursing facility. Anthem's responsibility for non-facility services continues for its members while they are still enrolled with Anthem. After the Kentucky Medicaid Program completes the managed care disenrollment process and reinstates the member in the fee-for-service Medicaid program, Anthem no longer has financial responsibility for ancillary, physician and pharmaceutical services.

8.4 Emergent Admissions

Anthem requests hospitals to notify Anthem within one business day of emergent admissions. hospitals can call Anthem's National Customer Care department 24 hours a day, 7 days a week, including federal holidays, at **855-661-2028** or fax at **800-964-3627**. Failure to notify Anthem of an emergent admission within one business day will result in an administrative denial of the inpatient stay.

Anthem's medical management staff will verify eligibility and determine medical necessity of the admission. A concurrent review nurse will review and authorize the medical necessity of emergent admissions. Anthem's medical management staff will verify eligibility and determine coverage. . Failure to provide clinical information will result in a denial.

Documentation must be complete. Anthem will notify the hospital to submit additional documentation as necessary.

Failure to obtain precertification for selected elective procedures or services can result in an administrative denial.

If Anthem's medical director denies coverage, the attending provider will have an opportunity to discuss the case with him or her. The attending emergency room physician or provider actually treating the member is responsible until, and to determine when, the member is stabilized. Anthem will provide written notification to the facility, member and provider, and include the appeal rights for both members and providers, as well as the member's fair hearing rights. The medical necessity appeal process is outlined in section 10.2.3 of this manual.

8.5 Emergency Services

Emergency services require no precertification. Anthem does not deny access to or discourage Anthem members from using 911 or accessing emergency services when warranted. As a matter of course, Anthem grants authorizations for these services immediately.

Anthem will not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms. . When a member seeks emergency services at a hospital, he or she is examined by a licensed physician to determine if a need exists for such services. The physician will note the results of the emergency medical screening examination on the member's chart.

If there is a concern about transferring the member, Anthem defers to the judgment of the attending physician.

Any transfer from a non-network hospital to a network hospital can only take place after the member is medically stable. A non-emergent, elective transfer from one facility to another for the same or lower level of care requires prior authorization.

8.6 Inpatient Admissions

Notification is required within 24 hours or by the next business day for any inpatient admission, whether emergent or previously authorized. To send notification, the provider can:

- Call Provider Services 24 hours a day, 7 days a week at **855-661-2028**
- Fax the request to **800-964-3627**
- Submit through Availity Essentials [Availity.com](https://www.availity.com). Select Patient Registration > Authorizations & Referrals.

Failure to provide admission notification in a timely manner (24 hours or next business day of admit date) could result in an administrative denial of the entire inpatient admission.

Anthem requires precertification of all inpatient admissions.* The referring PCP or specialist is responsible for precertification. Submit requests for precertification with all supporting documentation immediately upon identifying the inpatient request or at least 72 hours prior to the scheduled or rescheduled admission. This will allow Anthem to verify benefits and process the precertification

request. For services that require precertification, Anthem makes case-by-case determinations that consider the individual's healthcare needs and medical history in conjunction with nationally recognized standards of care. The hospital can confirm that a precertification is on file by:

- Visiting the digital authorization application on Availity Essentials [Availity.com](https://www.availity.com).
Select Patient Registration > Authorizations & Referrals.
- Calling Provider Services at **855-661-2028**

If the request does not meet criteria for approval, the requesting provider will be afforded the opportunity to discuss the case with the medical director, within seven calendar days of the date of denial.

Anthem is available 24 hours a day, 7 days a week, including federal holidays, to accept precertification requests. When a request is received from the physician online, via telephone or fax, a care specialist will verify eligibility and benefits. This information will be forwarded to the precertification nurse.

Anthem's precertification nurse will review the coverage request and the supporting medical documentation to determine the medical appropriateness of all procedures. When appropriate, an Anthem precertification nurse will assist the physician in identifying alternatives for healthcare delivery as supported by the medical director.

When the clinical information received is in accordance with the definition of medical necessity and in conjunction with nationally recognized standards of care, Anthem will issue an Anthem reference number to the provider. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member's needs and medical history.

If the precertification documentation is incomplete or inadequate, the precertification nurse will not approve coverage of the request, but will notify the provider to submit the additional necessary documentation.

If the medical director denies coverage of the request, the appropriate denial letter (including appeal and the member's fair hearing appeal rights) will be mailed to the provider, facility and member.

*Precertification is not required for births or the inception of NICU services and shall not be required as a condition of payment. Continued hospital NICU stays require authorization.

8.7 Inpatient Reviews

Anthem must be notified within 24 hours or by the next business day if a member is admitted to the hospital (whether planned or emergent).

Inpatient Admission Review

Anthem will review all inpatient hospital admissions and urgent and emergent admissions within 24 hours from receipt of all necessary information. Anthem will determine the member's medical status through communication with the hospital's Utilization Review department.

Anthem will document the appropriateness of the stay and refer specific diagnoses to Anthem's case management staff for care coordination or case management.

Inpatient Concurrent Review

To determine the authorization of coverage, Anthem conducts a concurrent review of the hospital medical record by telephone, fax or electronic medical record.

Anthem will communicate approved days to the hospital for any continued stay.

8.8 Discharge Planning

Anthem's UM clinician coordinates members' discharge planning needs with:

- The hospital utilization review/case management staff
- The attending physician

For ongoing care, Anthem works with the provider to plan discharge with appropriate services such as:

- Home healthcare program (for example, home I.V. antibiotics)
- Hospice
- Acute rehab facility
- Outpatient treatment and follow-up

If expedited outpatient services are needed to facilitate discharge, an expedited fax line is available. The expedited UM fax line is **844-206-3452**.

8.9 Retrospective Review

Anthem will review all services provided during a period of retroactive eligibility. Retroactive Eligibility will be defined as the period of eligibility which is granted up to three months prior to the date of application for Medicaid coverage. Retrospective authorization requests should be submitted following the standard process for prior authorization, as timely as possible, once discovery of eligibility is made. **All requests should be clearly identified as "Retro Eligible" to assure reviews are processed correctly. Unidentified or poorly identified requests for retro eligible services may be denied in error, slowing the process for Anthem providers.** To assist Anthem in better serving the members and the provider, please indicate the period of retro eligibility so Anthem may confirm eligibility and the date(s) the services were provided.

Claims will be denied when authorization is not obtained for services which have an authorization requirement.

The request for retrospective review is separate from timely filing requirements. Claims may be submitted with clinical documentation for medical review through the claims filing process.

There are exceptions to the timely filing requirements. These include:

- Cases of coordination of benefits/subrogation. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date of the third party's resolution of the claim.
- Cases where a member has retroactive eligibility. In situations of enrollment in Anthem with a retroactive eligibility date, the time frames for filing a claim will begin on the date that Anthem receives notification from the enrollment broker of the member's eligibility/enrollment.

8.9.1 Medical Post Service Review

Anthem provides 24-hour-a-day, 7-day-a-week prior authorization services. Anthem recognizes that not all Anthem providers currently have the resources to facilitate reviews outside of normal business hours. For those services provided after business hours, 6 p.m. on Friday until 8 a.m. the following Monday, Anthem will accept Post Service Reviews no later than the next business day after the rendered service. Please submit Medical Post Service requests through the normal prior authorization process. These requests will be reviewed for medical necessity, and if not met, could be denied accordingly. Post Service Review does not apply to elective services scheduled in advance, performed during the times identified above. These services should be prior authorized. If these services are not prior authorized, services could be denied administratively; for example, elective services scheduled on a Thursday to be performed on Saturday.

Anthem urges providers to utilize the 24/7 prior authorization coverage whenever possible. It is the expectation of Anthem that all prior and post service requests be timely. Failure to obtain timely authorizations will lead to denials of services.

8.10 Nonemergent Outpatient and Ancillary Services

Anthem requires precertification from providers within 72 hours before services are rendered (at a minimum). Anthem requires precertification for coverage of certain non-emergent outpatient and ancillary services. For the most up-to-date precertification/notification requirements go to providers.anthem.com/ky. Precertification is also required for all services provided by nonparticipating providers. The written precertification procedures are readily accessible on the health plan's website for providers at providers.anthem.com/kentucky-provider/claims/prior-authorization-requirements.

For urgent or expedited requests, Anthem will make a decision as expeditiously as the member's health condition requires and no later than 24 hours after obtaining all necessary information per KRS 304.17A-607(1)(i). If documentation is not complete, Anthem will ask for additional necessary documentation. If all necessary information is not received, the health plan has up to 2 business days after receipt of the request for service to make the utilization review decision and provide notice per Kentucky Medicaid Managed Care Contract (or 3 calendar days per NCQA, whichever is lesser).

Definition of urgent: For cases in which a provider indicates that following standard time frame would seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

Urgent healthcare services include all participating requests for hospitalization and outpatient surgery.

8.11 Peer-to-Peer Discussion

If the medical director denies coverage of a request, the appropriate notice of proposed action, including the member's appeal rights, will be mailed to the member and provider.

If the request does not meet medical necessity criteria for approval, the requesting provider will be afforded the opportunity to discuss the case with the medical director within seven calendar days from the date of denial. A peer-to-peer is not considered to be an appeal and does not limit subsequent appeal rights. The peer-to-peer process does not affect the appeal time frame. A peer-to-peer discussion can be arranged by calling **855-661-2028**

8.12 Prenatal Ultrasounds

The following are frequently asked questions and answers about Anthem’s prenatal ultrasound policies.

<p>What are the preauthorization/precertification requirements for total obstetric care?</p>	<p>For obstetric care, Anthem does not require preauthorization. Anthem only requires notification to the Provider Services team at 855-661-2028 or fax to 800-964-3627.</p>
<p>In which trimester of a woman’s pregnancy is she determined to be an obstetric patient?</p>	<p>A member is considered to be an obstetric patient once pregnancy is verified.</p>
<p>Are there prior authorization requirements for prenatal ultrasound?</p>	<p>There are no prior authorization requirements for prenatal ultrasound studies. Payment is administered by matching the procedure with the appropriate diagnosis code submitted on the claim.</p>
<p>Is there a medical policy covering prenatal ultrasound procedure?</p>	<p>Yes, there is a detailed policy covering certain prenatal ultrasound procedures. To review the complete policy (CG-MED-42 Maternity Ultrasound in the Outpatient Setting), please:</p> <ul style="list-style-type: none"> • Go to providers.anthem.com/ky • Select Maternity Ultrasound in the Outpatient Setting from the policy list <p>The policy describes coverage of ultrasound studies for maternal and fetal evaluation as well as for evaluation and follow-up of actual or suspected maternal or fetal complications of pregnancy.</p>
<p>Are there limits on the number of prenatal ultrasound procedures a woman may have during her pregnancy?</p>	<p>There are no limits on the number of prenatal ultrasound procedures that are medically necessary. Prenatal ultrasounds for fetal and maternal evaluations or for follow-up of suspected abnormalities are covered when medically necessary and supported by the appropriate diagnosis code for the ultrasound study performed.</p> <p>Not all diagnosis codes are acceptable and appropriate for all ultrasounds. When submitted incorrectly, a claim will be denied.</p>
<p>Which ultrasound procedures are covered?</p>	<p>The policy does not apply to ultrasound studies with CPT codes not specifically listed below such as nuchal translucency screening, biophysical profile and fetal echocardiography.</p> <p>For CPT codes 76801 (+76802) and 76805 (+76810), one routine ultrasound study is covered per pregnancy.</p> <p>For CPT codes 76811 (+76812), 76815, 76816 and 76817, additional ultrasound studies are covered when medically necessary and supported by the appropriate diagnosis code for the ultrasound study being requested.</p>

Are there exceptions?	<p>The policy does not apply to the following specialists:</p> <ul style="list-style-type: none"> • Maternal fetal medicine specialists • Radiology specialists <p>The policy also does not apply to ultrasounds performed in place of service code 23 — emergency department.</p>
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8.13 Urgent Care/After-hours Care

Anthem requires members to contact the member’s PCP if the need for care is urgent. If the provider is unable to see the member, the provider can refer him or her to one of Anthem’s participating urgent care centers or another provider who offers after-hours care. Precertification is not required.

Anthem strongly encourages PCPs to provide evening and Saturday appointment access.

8.14 Members with Special Needs

Adults with special needs include those members with complex/chronic medical conditions requiring specialized healthcare services, including persons with physical, behavioral and/or developmental disabilities. Children with special healthcare needs are those members who have or are at an increased risk for a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required generally by children. The Health Plan employs reasonable efforts to identify ISHCN's based on the following populations:

- Children in/or receiving Foster Care or adoption assistance, if applicable.
- Blind/Disabled Children under age nineteen (19) and Related Populations eligible for SSI
- Adults over the age of sixty-five (65)
- Homeless
- Individuals with chronic physical health illnesses
- Individuals with chronic behavioral health illnesses
- Children receiving EPSDT Special Services; and
- Children receiving services in a Pediatric Prescribed Extended Care facility or unit.

Anthem, through an intensive care management program, has processes in place to assist with:

- Well-child care
- Health promotion and disease prevention
- Specialty care for those who require such care
- Diagnostic and intervention strategies
- Therapies
- Ongoing ancillary services
- Long-term management of ongoing medical complications
- Prescribed Pediatric Extended Care
- Care management systems for assuring children with serious, chronic and rare disorders receive appropriate diagnostic workups on a timely basis

Anthem coordinates with qualified community health homes and contracts with community organizations such as chemical dependency facilities and long-term care agencies to provide a full range of health home services for members with special needs.

Anthem has policies and procedures to allow for continuation of existing relationships with out-of-network providers when considered to be in the best medical interest of the member.

Anthem, with the assistance of network providers, will identify members who are at risk of or have special needs. The identification will include the application of screening procedures for new members. These will include a review of hospital and pharmacy utilization. Anthem will develop care plans with the member and his or her representatives that address the member's service requirements with respect to specialist physician care, durable medical equipment, home health services, transportation, etc. The care management system is designed to ensure that all required services are furnished on a timely basis and that communication occurs between network and non-network providers if applicable.

Anthem works to ensure a new member with complex/chronic conditions receives immediate transition planning. The transition plan will include the following:

- Review of existing care plans
- Preparation of a transition plan that ensures continual care during the transfer to the plan

If a new member upon enrollment or a member upon diagnosis requires very complex, highly specialized healthcare services over a prolonged period of time, the member may receive care from a participating specialist or a participating specialty care center with expertise in treating the life-threatening disease or specialized condition.

Training sessions/materials and after-hours protocols for provider's staff will address members with special needs. Protocols must recognize that a non-urgent condition for an otherwise healthy member may indicate an urgent care need for a member with special needs.

Case/care managers, providers and Member Services staff are able to serve members with behavior problems associated with developmental disabilities, including the extent to which these problems affect the member's level of compliance.

Chapter 9: Quality Management

9.1 Quality Management Program

Anthem has a comprehensive Quality Management Program (QMP), designed to monitor and address the demographic and epidemiological needs of the population served, with a focus on management and delivery of care in regard to:

- Individualized and culturally competent care
- Overall quality of care
- Member and provider satisfaction
- Medical, behavioral and quality of life outcomes
- Coordination and continuity of care across healthcare settings
- Network adequacy
- Provider availability
- Cultural competency
- Preventive health
- Condition Care, Case Management and Behavioral Health Management
- Member complaints, appeals and grievances
- Federal/State/Regulatory requirements
- Accreditation requirements

Providers in Anthem's network are contractually required to cooperate with quality improvement activities, which include providing requested member records in a timely manner, for the purpose of assessing quality of care. These activities are in accordance with the Health Insurance Portability and Accountability Act of 1996 (*HIPAA*) Privacy Rule at 45 CFR 164.506, which permits a covered entity (provider) to use and disclose Protected Health Information (PHI) to health plans without member authorization for information regarding treatment, payment and healthcare operations activities. This also includes conducting quality assessment and improvement activities.

As a provider in Anthem's network, the provider will have opportunities to make recommendations for areas of improvement and to voluntarily participate in Anthem's QI activities via committee representation, project participation and by providing feedback in Anthem provider surveys.

In addition, Anthem is committed to working collaboratively with network providers and hospitals to identify and address preventable adverse events, as a means of improving the quality of patient care among Anthem members.

9.2 Quality of Care and Preventable Adverse Events

Providers and healthcare systems, as advocates for Anthem members, are responsible for the continuous monitoring, implementation and enforcement of applicable healthcare standards. We strive and reinforce efforts to build a safer, equitable, high-quality healthcare system and decrease the occurrence of patient safety events, provider preventable conditions (PPCs) and hospital-acquired conditions (both referred to as HCACs). We advocate for a safety culture that improves the delivery of healthcare, health outcomes, and alignment with national patient safety efforts. In doing so, we are committed to working collaboratively with network providers and hospitals to promote safe practices

and to identify and implement appropriate strategies, processes, and technologies to address and avoid PPCs and HCACs, including as it applies to health disparities. Anthem's goal is to enhance the quality of care received not only by members but by all patients receiving care within individual practices and across the healthcare continuum.

The breadth and complexity of today's healthcare system means there are inherent risks, many of which can be neither predicted nor prevented. However, when there are preventable adverse events, risks should be tracked and reduced, with the ultimate goal of elimination.

Prevention of adverse events may require the disclosure of PHI. *HIPAA* specifies that PHI may be disclosed for the purpose of healthcare operations in relation to quality assessment and improvement activities. The information shared with Anthem is legally protected through the peer review process and will be maintained in a strictly confidential manner. If a provider receives a request for medical records, please provide the records within 10 days of the date of the request.

Provider preventable conditions and HCACs should not occur. When these events do occur, Anthem firmly supports the concept that a health plan and its members should not pay for resultant services, remaining consistent with CMS payment policy and as stated in Elevance's/Anthem's reimbursement policy/contracts.

Anthem will continue to monitor activities related to the list of adverse events from federal, state and private payers, including Never Events.

****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 healthcare providers.

Anthem evaluates all physicians, advanced registered nurse practitioners and physician assistants for compliance with:

- Medical community standards
- External regulatory and accrediting agencies requirements
- Contractual compliance

Anthem shares these reviews to enable the provider to increase individual and collaborative rates for members.

Anthem's quality program includes a review of quality of care issues for all care settings using:

- Member complaints
- Reported adverse events
- Other information

The results submitted to Anthem's Quality Management department are incorporated into a profile.

Please Note: Medicaid is prohibited from paying for certain **Healthcare Acquired Conditions (HCAC)**. This applies to all hospitals.

9.3 Quality Management Committee

Anthem's organization's Quality Management Committee oversees, analyzes and evaluates all Quality Management (QM) program activities.

The Quality Management Committee's (QMC) responsibilities are to:

- Perform and assess causal analyses, in order to identify process barriers, as well as cultural, language, financial and other demographic barriers
- Establish strategic direction and monitor and support implementation of quality management program activities, including but not limited to: performance improvement, clinical outcomes improvement and internal/external quality initiatives pertaining to improved access to care and services
- Establish processes and structure that ensures Department for Medicaid Services (DMS) contract and NCQA compliance
- Review planning, implementation, measurement and outcomes of clinical/service quality improvement studies
- Coordinate communication of quality management activities throughout the health plans
- Review HEDIS data and action plans for improvement
- Review accreditation data and action plans for improvement
- Review provider access/availability data and action plans for improvement
- Analyze member and provider satisfaction survey responses
- Review and approve the annual quality management program description
- Review and approve the annual work plans for each service delivery area
- Provide oversight and review of delegated services and subcommittees
- Receive and review reports of utilization review decisions and take action when appropriate
- Recommend policies or revisions to policies for effective operation of the QM program and the achievement of QI program objectives. Associated committees and subcommittees may also participate in these activities
- Ensure practitioner participation in the QM program through planning, design and implementation or review
- Facilitate practitioner participation in the QM program activities through attendance and discussion in relevant QM committee or QM subcommittee meetings or on ad hoc task forces
- Identifies actions to improve quality and prioritizes them based on significance
- Review and evaluate the organization's actions to determine effectiveness
- Development and review of clinical practice guidelines

9.4 Medical Policies and Clinical UM Guidelines

The Medical Policy & Technology Assessment Committee (MPTAC) is the authorizing body for medical policy and clinical Utilization Management (UM) guidelines (collectively, "Medical Policy"), which serve as a basis for coverage decisions. The Office of Medical Policy & Technology Assessment (OMPTA) develops Medical Policy for the company. The principal component of the process is the review for development of medical necessity and/or investigational policy position statements or clinical indications for the spectrum of services and/or procedures for which medical benefits are provided.

As of January 1, 2023, Anthem adopted MCG for medical necessity except for substance use. American Society of Addiction Medicine (ASAM) is adopted for substance use. If MCG does not cover a behavioral health service, the contractor shall adopt the following standardized tools for medical necessity determinations — for adults: Level of Care Utilization System (LOCUS); for children: Child and

Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths Scale (CANS); for young children; Early Childhood Service Intensity Instrument (ECSII).

If it is determined that one of the medical necessity criteria named in this section is not available or not specifically addressed for a service or for a particular population, Anthem submits its proposed medical necessity criteria to the Department for approval. Anthem has mechanisms to check the consistency of application of review criteria. CMS recognized guidelines, LCDs and NCDs, may be utilized when other criteria do not specifically address the provider request. The Department may also, at its discretion, require the use of other criteria it creates or identifies for services or populations not otherwise covered by the named criteria in this section.

Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first when determining eligibility for coverage. As such, in all cases, state Medicaid contracts or Centers for Medicare & Medicaid Services (CMS) requirements will supersede Anthem medical policy criteria. The Medical Advisory Committee helps us formalize and monitor the clinical practice guidelines and adopt the review criteria.

Anthem as a corporation and as individuals involved in Utilization Management (UM) decisions is governed by the following statements:

- UM decision making is based only on appropriateness of care and service and existence of coverage.
- Anthem does not specifically reward practitioners or other individuals for issuing denial of coverage or care. Decisions about hiring, promoting, or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that Anthem supports, or tend to support denials of benefits.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization, or create barriers to care and service.

The medical necessity criteria is transparent and meets all relative documentation requirements as required by the Department, the Kentucky Department of Insurance, CMS or other regulatory agencies. Criteria shall be readily available to review by the Department or the public by request and be available on Anthem Ky Medicaid's website.

Copies of the criteria used in a case to make a clinical determination may be obtained by calling Provider Services or Anthem's Kentucky health plan offices. Providers may also submit requests in writing to:

Healthcare Management Services
Anthem
13550 Triton Park Blvd., Third Floor
Louisville, KY 40223

9.5 Medical Advisory Committee

Anthem has established a Medical Advisory Committee (MAC) to:

- Assess levels and quality of care provided to members
- Recommend, evaluates and monitors standards of care

- Identify opportunities to improve services and clinical performance by establishing, reviewing and updating clinical practice guidelines based on review of demographics and epidemiologic information to target high-volume, high-risk and problem-prone conditions
- Oversee the peer review process
- Conduct network maintenance through the credentialing/recredentialing process
- Advise the health plan administration in any aspect of the health plan policy or operation affecting network providers or members
- Approve and provide oversight of the peer review process and the Utilization Review Program
- Approve and make recommendations of the clinical aspects of the QM Program
- Oversee and make recommendations regarding health promotion activities
- Use an ongoing peer review system to:
 - Monitor practice patterns
 - Identify appropriateness of care
 - Improve risk prevention activities
- Approve clinical protocols/guidelines
- Review clinical study design and results
- Develop action plans/recommendations regarding clinical quality improvement studies
- Consider/act in response to provider sanctions
- Oversee member access to care
- Review and provide feedback regarding new technologies
- Approve recommendations from subordinate committees

9.6 EPSDT Provider Toolkit

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a federally mandated comprehensive and preventative health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 and requires states to cover all services within the scope of the program. The intent is to focus on early prevention and treatment. Requirements include periodic screening, vision, dental and hearing services.

Services include:

- Screening
- Diagnosis and treatment
- Transportation and scheduling assistance

Screening must include:

- Comprehensive health and developmental history (inclusive of both physical and mental health)
- Comprehensive unclothed physical exam
- Appropriate immunizations
- Laboratory tests
- Lead toxicity screening
- Health education, including anticipatory guidance
- Vision services
- Dental services
- Hearing services

- Other necessary healthcare — diagnostic services and treatment to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services

Schedules used to determine when services are due:

- Bright Futures/American Academy of Pediatrics (AAP) Recommendations for Preventative Pediatric Healthcare
- Centers for Disease Control and Prevention Advisory Committee on Immunization Practices immunization recommendations schedule

The Anthem EPSDT program supports individual state plans by:

- Providing a repository to house EPSDT data
- Mailing annual preventative care recommendations to members
- Mailing reminders to members to schedule appointments

The Anthem EPSDT program includes additional member outreach activities and case management, as well as a provider pre-service report.

If providers have questions, call Provider Services at **855-661-2028** or visit providers.anthem.com/ky.

9.7 Credentialing Scope

Anthem credentials the following healthcare 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 and who provide treatment services under the health benefits plan
- Medical therapists (for example, 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 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 credentials the following health delivery organizations (HDOs):

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Nursing homes
- Free-standing surgical centers
- Behavioral health facilities providing mental health and/or substance abuse treatment in an inpatient, residential or ambulatory setting, including:
 - Adult family care/foster care homes
 - Ambulatory detox
 - Community mental health centers (CMHC)
 - Crisis stabilization units
 - Intensive family intervention services
 - Intensive outpatient- mental health and/or substance abuse
 - Methadone maintenance clinics
 - Outpatient mental health clinics
 - Outpatient substance abuse clinics
 - Partial hospitalization- mental health and/or substance abuse
 - Residential treatment centers (RTC)-psychiatric and/or substance abuse
- Birthing centers
- Convenient care centers/retail health clinics
- Intermediate care facilities
- Urgent care centers
- Federally qualified health centers (FQHC)
- Home infusion therapy agencies
- Rural health clinics

The following Health Delivery Organizations are not subject to professional conduct and competence review under Anthem's credentialing program, but are subject to a certification requirement process:

- 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

9.8 Credentials Committee

The decision to accept, retain, deny or terminate a practitioner's participation in a network or plan program is conducted by a peer review body, known as Anthem's Credentials Committee (CC).

The CC will meet at least once every 45 calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the vice president of Medical and Credentialing Policy will designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. The chair must be a state or regional lead medical director, or an Anthem medical director designee and the vice-chair must be a lead medical officer or an Anthem medical director designee, for that line of business not represented by the chair. In states or regions where only one line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five, but no more than ten external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types of credentialed health providers (e.g. nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair's discretion. At least two of the physician committee members must be credentialed for each line of business (e.g. Commercial, Medicare and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/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 of the right to review information submitted to support 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 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 detailing 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 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 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.

9.9 Nondiscrimination Policy

Anthem 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 will not discriminate against any applicant on the basis of the risk of the population served 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 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 Credentialing Program Standards. CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process.

9.10 Initial Credentialing

Each practitioner or HDO must complete a standard application form when applying for initial participation in one or more of Anthem networks or plan programs. This application may be a state mandated form or a standard form created by or deemed acceptable by Anthem. 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 the CAQH website at CAQH.org.

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

During the credentialing process, Anthem will review verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. The table below represents minimum requirements:

A. Practitioners:

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

A. Health Delivery Organizations (HDOs):

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

9.11 Recredentialing

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

During the recredentialing process, Anthem 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 Credentialing Program are required to be recredentialled every three (3) years unless otherwise required by contract or state regulations.

9.11.1 Health Delivery Organizations

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

Recredentialing of HDOs occur every three (3) years unless otherwise required by regulatory or accrediting bodies. Each HDO applying for continuing participation in networks or plan programs must submit all required supporting documentation.

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

9.12 Ongoing Sanction Monitoring

To support certain credentialing standards between the recredentialing cycles, Anthem has established an ongoing monitoring program. Credentialing performs ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department will review periodic listings/reports within 30 calendar days of the time the reports 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 Dept. (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes and satisfaction data, as available)
7. Other internal Anthem departments
8. Any other verified information received from 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 CC, review by the Anthem Medical Director, referral to the CC, or termination. Anthem credentialing departments will report practitioners or HDOs to the appropriate authorities as required by law.

9.13 Appeals Process

Anthem has established policies for monitoring and recredentialing practitioners and HDOs who seek continued participation in one or more of Anthem's plan programs or networks. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Anthem may wish to terminate practitioners or HDOs. Anthem also seeks to treat network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners in Anthem's networks for professional competence and conduct reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB). Additionally, Anthem will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is the intent of Anthem to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one or more of Anthem's network 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 Anthem's 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.

9.14 Reporting Requirements

When Anthem takes a professional review action with respect to a practitioner's or HDO's participation in one or more plan programs or networks, Anthem may have an obligation to report such to the NPDB. Once Anthem 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.

9.15 Anthem Credentialing Program Standards

I. Eligibility Criteria:

Healthcare practitioners

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

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

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

- A. For MDs, DOs, DPMs and oral and maxillofacial surgeons, the applicant must have a 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 the MDs, DOs, DPMs and oral and maxillofacial surgeons are applying. Individuals will be granted five years after completion of the residency program to meet this requirement.
 1. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
 - a. Previous board certification (as defined by one of the following: ABMS, AOA, RCPSC, CFPC) in the clinical specialty or subspecialty for which the MDs and DOs are applying which has now expired AND a minimum of 10 consecutive years of clinical practice. OR
 - b. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty. OR
 - c. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of the individual specialty AND a faculty appointment of Assistant Professor or higher at an academic medical center and teaching facility in Anthem's network AND the applicant's professional activities are spent at that institution at least 50% of the time.
 2. Practitioners meeting one of the three alternative criteria (a, b, c) will be viewed as meeting all Anthem education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Anthem review and approval. Reports submitted by delegate to Anthem must contain sufficient documentation to support the above alternatives, as determined by Anthem.
- B. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (NIAHO), 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.

II. Criteria for Selecting Practitioners

New Applicants (Credentialing):

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 timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies;

4. No evidence of potential material omission(s) on application;
5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to covered individuals;
6. No current license action;
7. No history of licensing board action in any state;
8. No current federal sanction and no history of federal sanctions (per System for Award Management (SAM), OIG and OPM report nor on NPDB report);
9. Possess a current, valid and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat covered individuals. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating covered individuals. Practitioners who treat covered individuals in more than one state must have a valid DEA/CDS for each applicable state.
 Initial applicants who have NO DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he/she has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:
 - a) It can be verified that this application is pending.
 - b) The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained.
 - c) The applicant agrees to notify Anthem upon receipt of the required DEA/CDS registration.
 - d) Anthem will verify the appropriate DEA/CDS registration via standard sources.
 - i. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a ninety (90) day timeframe will result in termination from the network.
 - ii. Initial applicants who possess a DEA/CDS registration in a state other than the state in which the applicant 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 the following criteria are met:
 - a) It can be verified that this application is pending and,
 - b) The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained,
 - c) The applicant agrees to notify Anthem upon receipt of the required DEA/CDS registration,
 - d) Anthem will verify the appropriate DEA/CDS via standard sources; applicant agrees that failure to provide the appropriate DEA/CDS registration within a ninety (90) calendar day timeframe will result in termination from the network, AND
 - e) Must not be currently federally sanctioned, debarred, or excluded from participation in any of the following programs: Medicare, Medicaid, or FEHBP.
10. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions;
11. No history of or current use of illegal drugs or history of or current alcoholism;
12. No impairment or other condition which would negatively impact the ability to perform the essential functions in the professional field;
13. No gap in work history greater than six months in the past five years with the exception of those gaps related to parental leave or immigration where 12-month gaps will be acceptable. Other gaps in work history of 6-24 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.

14. No history of criminal/felony convictions or a plea of no contest;
15. A minimum of the past 10 years of malpractice case history is reviewed.
16. Meets Credentialing Standards for education/training for specialty (ies) in which practitioner wants to be listed in an Anthem network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs and oral & maxillofacial surgeons;
17. No involuntary terminations from an HMO or PPO;
18. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
 - a) Investment or business interest in ancillary services, equipment or supplies;
 - b) Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
 - c) Voluntary surrender of state license related to relocation or nonuse of said license;
 - d) An NPDB report of malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
 - e) Non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business)
 - f) Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window;
 - g) Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
 - h) History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.
19. No QI data or other performance data including complaints above the set threshold.
20. Recreational at least every three years to assess the practitioner's continued compliance with Anthem standards.

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

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

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

1. Licensed Clinical Social Workers (LCSW) or other master level social work license type:
 - a. Master or doctoral degree in social work with emphasis in clinical social work from a program accredited by the Council on Social Work Education (CSWE) or the Canadian Association on Social Work Education (CASWE).
 - b. Program must have been accredited within three years of time the practitioner graduated.
 - c. Full accreditation is required, candidacy programs will not be considered.
 - d. If master's level degree does not meet criteria and practitioner obtained PhD 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.
2. Licensed professional counselor (LPC) and marriage and family therapist (MFT) or other master level license type:
 - a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental health field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
 - b. Master or doctoral degrees in divinity do not meet criteria as a related field of study.
 - c. Graduate school must be accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, (CACREP), or Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) listings. The institution must have been accredited within three years of the time the practitioner graduated.
 - d. 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 criteria this doctoral program must either be accredited by the APA or be regionally accredited by the CHEA. In addition, a doctoral degree in one of the fields of study noted above from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.
 3. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
 - a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing. Graduate school must be accredited from an institution accredited by one of the Regional Institutional Accrediting Bodies within three years of the time of the practitioner's graduation.
 - b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
 - c. Certification by the American Nurses Association (ANA) in psychiatric nursing. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner.
 - d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating covered individuals.
 4. Clinical Psychologists:
 - a. Valid state clinical psychologist license.
 - b. Doctoral degree in clinical or counseling, psychology or other applicable field of study from an institution accredited by the APA within three years of the time of the practitioner's graduation.
 - c. Education/Training considered as eligible for an exception is a practitioner whose doctoral degree is not from an APA accredited institution, but who is listed in the National Register of Health Service Providers in Psychology or is a Diplomat of the American Board of Professional Psychology.

- d. Master’s level therapists in good standing in the network, who upgrade license to clinical psychologist as a result of further training, will be allowed to continue in the network and will not be subject to the above education criteria.
5. Clinical Neuropsychologist:
- a. Must meet all the criteria for a clinical psychologist listed in C.4 above and be Board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN).
 - b. A practitioner credentialed by the National Register of Health Service Providers in Psychology with an area of expertise in neuropsychology may be considered.
 - c. Clinical neuropsychologists, who are not Board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
 - i. Transcript of applicable pre-doctoral training, OR
 - ii. Documentation of applicable formal one year post-doctoral training (participation in CEU training alone would not be considered adequate), OR
 - iii. Letters from supervisors in clinical neuropsychology (including number of hours per week), OR
 - iv. Minimum of five years of experience practicing neuropsychology at least 10 hours per week.
6. Licensed Psychoanalysts:
- a. Applies only to Practitioners in states that license psychoanalysts.
 - b. Practitioners will be credentialed as a licensed psychoanalyst if the practitioner is not otherwise credentialed as a practitioner type detailed in Credentialing Policy (e.g. psychiatrist, clinical psychologist, licensed clinical social worker).
 - c. Practitioner must possess a valid psychoanalysis state license.
 - i. Practitioner shall possess a master’s or higher degree from a program accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, CACREP, or the COAMFTE listings. The institution must have been accredited within three years of the time the Practitioner graduates.
 - ii. Completion of a program in psychoanalysis that is registered by the licensing state as licensure qualifying; or accredited by the American Board for Accreditation in Psychoanalysis (ABAP) or another acceptable accrediting agency; or determined by the licensing state to be the substantial equivalent of such a registered or accredited program.
 - 1. A program located outside the United States and its territories may be used to satisfy the psychoanalytic study requirements if the licensing state determines the following: it prepares individuals for the professional practice of psychoanalysis; and is recognized by the appropriate civil authorities of that jurisdiction; and can be appropriately verified; and is determined by the licensing state to be the substantial equivalent of an acceptable registered licensure qualifying or accredited program.
 - 2. Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
 - 3. Meet examination requirements for licensure as determined by the licensing state.

9.16 HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation; Anthem may evaluate the most recent site survey by Medicare or the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past 36 months. Non-accredited HDOs are subject to individual review by the CC and will be considered for covered individual access need only when the CC review indicates compliance with Anthem standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are recredentialed at least every three years to assess the HDO's continued compliance with Anthem standards.

A. General Criteria for HDOs:

1. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to covered individuals. The license must be in good standing with no sanctions.
2. Valid and current Medicare certification.
3. Must not be currently federally sanctioned, debarred, or excluded from participation in any of the following programs; Medicare, Medicaid or the FEHBP. Note: If, once an HDO participates in the Anthem's programs or provider network(s), exclusion from Medicare, Medicaid or FEHBP occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider network(s). Special consideration regarding the HDO's continued participation in the Anthem's other credentialed practitioner network(s) 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 information will be brought to the Anthem's geographic Credentials Committee for consideration and final determination, without HDO appeal rights related to the special provider network(s), if such participation would be permitted under applicable State regulation, rule or contract requirements.
4. Liability insurance acceptable to Anthem
5. If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if Anthem's quality and certification criteria standards have been met.

B. Additional Participation Criteria for HDO by Provider Type:

HDO Type and Anthem Approved Accrediting Agent(s)

(A) Medical Facilities

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Acute Care Hospital	CIQH, CTEAM, HFAP, DNV/NIAHO, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC
Birthing Center	AAAHC, CABC
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

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Free-Standing Surgical Centers	AAAASF, AAPSF, HFAP, IMQ, TJC
Home Healthcare 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 Clinic (UCC)	AAAH, IMQ, TJC, UCAOA

(B) Behavioral Health

Facility Type (Behavioral Health)	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)	AAAH, 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

(C) Rehabilitation

Facility Type (Behavioral Healthcare)	Acceptable Accrediting Agencies
Acute Care 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

Chapter 10: Provider Grievance and Payment Dispute Procedures

10.1 Provider Grievance Procedures

A grievance is a notice of concern submitted to the health plan from a provider expressing dissatisfaction and requesting action, such as an investigation. A provider grievance may fall into one of the following categories: Process/Polices, Claims Processing (Not Claim Appeal), Communications, Fraud/Waste/Abuse, Contracting/Credentialing, Member or Other. .

The provider can submit verbal or written grievances. Supporting documentation should accompany the grievance. Grievances are resolved fairly and are consistent with Anthem policies and covered benefits. Anthem does not discriminate or take punitive action against a provider for filing a grievance.

Grievances are documented in the electronic tracking system, Kentucky Network Management Assistance Tracker (K-NART), upon receipt and electronically routed to the appropriate party. Anthem will document date filed, type of issue, identification and contact of the individual filing the grievance or appeal, identification of the individual recording the grievance or appeal, disposition of the grievance or appeal, corrective action required and date resolved. The internal provider relationship management representative will send a written acknowledgement of the provider's grievance within five business days of the receipt date.

The grievance is then assigned to the appropriate provider relationship management representative to investigate the provider's grievance and propose a resolution. Anthem may request medical records or a provider explanation of the issues raised in the grievance by telephone or with a signed and dated letter via fax/e-mail. Providers are expected to comply with the request within 10 days of the date of the request for information.

If additional time is needed for research/resolution, a 14-day extension letter will be issued to the provider. For all cases, Anthem's designated staff sends a written resolution letter to the provider within 30 calendar days of the receipt of the grievance or at the end of the 14-day extension period. The resolution letter notifies the provider of the opportunity to file a grievance with those entities with which Anthem subcontracts, such as a dental or vision vendor. When the internal provider relationship management representative sends the resolution letter to the provider, Anthem closes the grievance file electronically in K-NART.

If providers are dissatisfied with the grievance resolution, providers have the right to arbitration (handled per the Anthem provider agreement).

The provider grievance form can be found at providers.anthem.com/ky.

10.1.1 Verbal Grievance Procedures

Submit verbal grievances to:

- Provider Services at **855-661-2028** or Health Care Networks at **800-205-5870**
- The Anthem website: providers.anthem.com/ky
- The local provider relationship management representative.

All provider calls will be answered immediately during normal business hours. Inquiries will be resolved and/or results will be communicated to the provider within 30 business days of receipt. If inquiries are not resolved within 30 days, Anthem may request a 14-day extension to resolve the issue.

10.1.2 Written Grievance Process

Submit a grievance in writing by letter or fax to:

Health Care Networks
Anthem
13550 Triton Park Blvd., Third Floor
Louisville, KY 40223
Fax: **855-384-4872**

If the outcome of Anthem's review is not favorable to the provider, Anthem will provide a written notice of adverse action.

The provider can also appear in person at the following office to submit a complaint:

Anthem
13550 Triton Park Blvd.
Louisville, KY 40223

10.2 Provider Appeals

Anthem will allow providers to have the right to file an internal appeal with Anthem regarding denial of the following:

- A healthcare service;
- Claim for reimbursement;
- Provider payment;
- Contractual issues.

The following sections outline the process for each appeal type. Providers should also be aware that Members have appeal and grievance rights as outlined in 42 C.F.R. 438.10(g)(2)(XI).

10.2.1 Claims Payment Appeals or Inquiries

Anthem's Health Care Networks program helps the provider with claims payment and issue resolution.

Contact Provider Services by calling 855-661-2028 and select the Claims prompt within Anthem's voice portal.

Anthem will connect the provider with a dedicated resource team, called the Provider Service Unit (PSU), to ensure:

- Availability of helpful, knowledgeable representatives to assist the provider
- Increased first-contact, issue resolution rates
- Significantly improved turnaround time of inquiry resolution

10.2.2 Claims Correspondence

The PSU is available to assist the provider in determining the appropriate process to follow for resolving provider claim issues.

The following table also provides guidance on issues considered claim correspondence and should not go through the Payment Appeal process.

Type of Issue	What Do I Need to Do?
Rejected Electronic Claim(s)	Contact your EDI vendor or Availity at 800-282-4548 when the provider's claim was submitted electronically but was never paid or was rejected. Claims submitted electronically will return response reports that may contain rejections. Availity is available to assist the provider with setup questions and help resolve submission issues or electronic claims rejections.
Remit Requests for Supporting Documentation (Sterilization/Hysterectomy/Abortion Consent Forms, itemized bills and invoices)	Submit a claim correspondence form, a copy of the provider's remit and the supporting documentation to: Claims Correspondence Anthem P.O. Box 62429 Virginia Beach, VA 23466-2429
Remit Requests for Medical Records	Submit a Claim Correspondence form, a copy of the provider's remit and the medical records to: Claims Correspondence Anthem P.O. Box 62429 Virginia Beach, VA 23466-2429
Need to submit a corrected claim due to errors or changes on original submission	Submit a Claim Correspondence form and the provider's corrected claim to: Claims Correspondence Anthem P.O. Box 61010 Virginia Beach, VA 23466- 1010 Clearly identify the claim as corrected. Anthem cannot accept claims with handwritten alterations to billing information. Anthem will return claims that have been altered with an explanation of the reason for the return. For corrected electronic claims or web submissions using Availity Essentials use one the following frequency codes with the original claim number: <ul style="list-style-type: none"> • 7 – Replacement of Prior Claim • 8 – Void/Cancel Prior Claim
Submission of coordination of benefits/third-party liability information	Submit a Claim Correspondence form, a copy of the provider's remit and the COB/TPL information to: Claims Correspondence Anthem P.O. Box 61010 Virginia Beach, VA 23466-1010

10.2.3 Medical Necessity Appeals

Appeal requests may be completed by the member, the member's representative, the provider or the provider on behalf of the member with written member consent, either verbally, in writing or in person at the health plan's physical location. An appeal may be filed for any covered medical services, including EPSDT screenings and EPSDT Special Services:

- For an appeal of standard service authorization decisions, a member or provider must file an appeal, either orally or in writing, within 60 calendar days of the date on the Anthem notice of action. This also applies to a member or provider's request for an expedited appeal.
- For an appeal for termination, suspension or reduction of previously authorized services when the member/provider requests continuation of such services, the member or provider must file an appeal within 10 calendar days of the date of the Anthem mailing of the notice of action.
- Oral inquiries seeking to appeal actions shall be treated as appeals and will be confirmed in writing, unless the member or provider requests expedited resolution.
- A provider may request a three member committee review in lieu of a traditional provider level one appeal conducted at the health plan. This is offered to make decision on provider appeals only. The committee will consist of three qualified individuals who were not involved in the original decision, action or inaction giving rise to the right to appeal. Providers must request a committee review within 60 days of the adverse benefit determination notification. The request should be sent to the health plan electronically, by fax. The provider committee review must meet all contractual timelines required for other appeal methodologies outlined in the contract and required by the CFR. Acknowledgement and decision notifications will occur within the same timelines and by the same methodologies as other appeal decisions as outlined in the contract and required by the CFR.
- A provider may request a State Fair Hearing on behalf of a member once appeal rights are exhausted, if the provider is acting as the member's authorized representative and that authorization is in writing.
- A provider may file a request for an external independent third party review of a previously appealed decision with an undesirable outcome within 60 days. No new information can be provided for this review. The review is coordinated by the Office of the Ombudsman and Administrative.
 - a. The 60-day count shall begin on one of the following dates:
 - i. Date that the adverse determination was received electronically, if received electronically
 - ii. Date that the adverse determination was received via fax, per the date and time documented on the fax transmission, if the notice was faxed
 - iii. Post mark date on the envelope containing the adverse determination, if the adverse determination was sent via postal mail; an additional three days shall be added when the service is by mail
- The provider may request an Administrative Hearing for decisions that were unfavorable on appeal and external independent third party review. An appeal shall be filed within 30 days from the appealing party's receipt of the final decision of the external independent third party review. A decision of the administrative hearing tribunal shall be final for purposes of judicial appeal.

Anthem's goal is to handle and resolve every appeal as quickly as the member's health condition requires. Anthem's established time frames are as follows:

- **Standard resolution of appeal and for appeals for termination, suspension or reduction of previously authorized services:** 30 calendar days from the date of receipt of the appeal, unless the provider, the member, or DMS approves an extension of 14 calendar days as necessary to complete the appeal. In all circumstances, the appeal determination must not be extended beyond 44 calendar days from the day Anthem receives the appeal request.
- **Expedited resolution of appeal, including notice to the affected parties:** as expeditiously as the medical condition requires, but no later than 72 hours from receipt of the appeal, unless the provider, the member or DMS approves that an extension of 14 calendar days is necessary to complete the appeal. The notice of the resolution of the appeal shall be in writing. For notice of an expedited resolution, Anthem will also make reasonable efforts to provide prompt oral notice. Anthem will include the date completed and reasons for the determination in easily understood language. A written statement of the clinical rationale for the decision, including how the requesting provider or enrollee may obtain the utilization management clinical review or decision-making criteria, will be issued. If the request for expedited resolution is denied, the appeal will be transferred to the standard resolution timeframe and written notification will be provided within 72 hours from receipt of the appeal.

Anthem makes every reasonable effort to give the member or his or her representative verbal notification and then follow it up with a written notification.

Anthem will inform the member or provider of the limited time he or she has to present evidence and allegations of fact or law with expedited resolution. Anthem also ensures that no punitive action will be taken against a provider who supports an expedited appeal.

Anthem will send members or provider's a written notice of the results of the resolution. The notice will include:

- The date completed
- Reasons for the determination in easily understood language
- A written statement of the clinical rationale for the decision, including how the requesting provider or member may obtain the Utilization Management clinical review or decision-making criteria

If an appeal is not wholly resolved in favor of the member or provider, the notice will include:

- The right for Anthem member to request a state fair hearing and how to do so for member requested appeals or on behalf of the member.
- The right to receive benefits while this hearing is pending and how to request them if requested by the member or on behalf of the member.
- Notice that the member may have to pay the cost of these benefits if the state fair hearing officer upholds the Anthem action if requested by the member or on behalf of the member.
- The right of the provider to request an external third party review of the decision and how to do so for provider requested appeals.

10.2.4 Payment Appeals

A payment appeal is any dispute between the provider and Anthem for reason(s), including:

- Contractual payment issues
- Retrospective review
- Disagreements over reduced or zero-paid claims

- Authorization issues
- Timely filing issues
- Other health insurance denial issues
- Claim code editing issues
- Duplicate claim issues
- Retro-eligibility issues
- Experimental/investigational procedure issues
- Claim data issues

The provider will not be penalized for filing a payment appeal. No action is required by the member.

Anthem’s procedure is designed to afford providers access to a timely payment appeal process. If a provider is dissatisfied with a previously processed claim or adjustment, the provider has the right to file an appeal for review of the claim or adjustment.

Due to the nature of appeals, some cannot be accepted verbally and therefore must be submitted in writing if additional documentation or explanation is required. The following table provides recommendations on submission methods based on the appeal reason:

Issue Type	Verbal Allowed?
Denied for Timely Filing	<ul style="list-style-type: none"> • If Anthem made an error per the provider’s contract, verbal is appropriate • If the provider has paper proof, then written is most appropriate
Denied for No Authorization	<ul style="list-style-type: none"> • If the provider knows an authorization was provided and Anthem made an error, verbal is appropriate • If the provider has paper proof, then written is most appropriate
The provider feels payment was not paid according to the contract, such as at appropriate DRG or per diem rate, fee schedule, Service Case Agreement or appropriate bed type, etc.	<ul style="list-style-type: none"> • Verbal is appropriate
Experimental/Investigational procedure denial	<ul style="list-style-type: none"> • Written is most appropriate

As appropriate, verbal appeals can be submitted by calling Provider Services at **855-661-2028**.

If the appeal must be submitted in writing or if the provider wishes to use the written process instead of the verbal process, the appeal should be submitted to:

Claim Appeals
 Anthem
 P.O. Box 62429
 Virginia Beach, VA 23466-1599

Written appeals with supporting documentation can also be submitted via the Payment Appeal tool on the Anthem provider website.

Use the secure Provider Availity Payment Appeal Tool at [Availity.com](https://www.availity.com). Through Availity, you can upload supporting documentation and receive immediate acknowledgement of your submission. Locate the claim you want to dispute using Claim Status from the Claims & Payments menu. Select Dispute Claim to initiate the dispute. From the Claims & Payments menu select Appeals to locate the initiated dispute, upload supporting documentation and submit.

Payment appeals, whether verbal or written, must be received by Anthem within 90 calendar days of the remittance date.

When submitting the appeal, the provider will need to provide a listing of disputed claims, a detailed explanation of the reason for the appeal, and supporting statements for verbal appeals and supporting documentation for written; written appeals should also include a copy of the remit and an Appeal Request form. The Kentucky universal appeal form can be found at:

providers.anthem.com/docs/gpp/KY_CAID_Forms_MCOProviderAppeal.pdf?v=202104150107

Verbal appeals received by Provider Services are logged into the appeal database. Written payments appeals are received in Anthem's Document Management Department (DMD) and are date-stamped upon receipt. The DMD scans the appeal into Anthem's document management system, which stamps the image with the received date and the scan date. Once the dispute is scanned, it is logged into the appeal database by the Intake team within the DMD.

Once the appeal is logged, it is routed in the database to the appropriate appeal unit. The appeal associate works appeals by demand, drawing items based first-in, first-out criteria for routing appeals.

The appeal associate will:

- Review the appeal and determine the next steps needed for the payment appeal
- Make a final determination if able based on the issue or route to the appropriate functional area(s) for review and determination
- Ensure a determination is made within 30 calendar days of the receipt of the payment appeal
- Request a 14-day extension from the provider if the appeal will not be resolved within the 30 days. If the provider requests the extension, the extension shall be approved.
- Contact the provider via the provider's preferred method of communication (phone, fax, email or letter) and provide the payment information, if overturned, or further appeal rights are upheld or partially upheld; the provider's preferred method of communication is determined from the Provider Services agent requesting this information during the provider's call or selection on the Appeal Request form; if no preference is provided, a letter will be mailed to the provider.

When payment appeals are received with supporting clinical documentation, Anthem will apply established clinical criteria to the payment appeal. After review, Anthem will either approve the payment dispute or forward it to the medical director for further review and resolution.

10.2.5 Binding Arbitration

In the event of a dispute arising out of this agreement that is not:

- Within the scope of relationship management set forth in the agreement or

- Resolved by informal discussions among the parties, the parties shall attempt to negotiate the dispute

Any party may initiate negotiation by sending a written description of the dispute to the other parties via certified or registered mail, overnight mail, or personal delivery. The description shall explain the nature of the dispute in detail and set forth a proposed resolution, including a specific time frame within which the parties must act. The party receiving the letter must respond in writing within 30 days with a detailed explanation of its position and a response to the proposed resolution. Within 30 days of the initiating party receiving this response, principals of the parties who have authority to settle the dispute will meet to discuss the resolution of the dispute. The initiating party shall initiate the scheduling of this negotiation session.

In the event the parties are unable to resolve the dispute following the negotiation, a party shall have the right to pursue all available remedies at law or equity, including injunctive relief.

In order to invoke the dispute resolution procedures, a party first shall send to the other party a written demand letter that contains a detailed description of the dispute and all relevant underlying facts, a detailed description of the amount(s) in dispute and how they have been calculated with respect to such dispute.

10.3 State Hearing Process

10.3.1 State Hearings for the Member

The member or the member's authorized representative may request a hearing. A provider may not request a hearing on behalf of a member unless the member deems, in writing, the provider to be his or her authorized representative.

The member must exhaust all levels of resolution and appeal within the Anthem appeal system prior to filing a request for a hearing with the Kentucky Cabinet for Health and Family Services.

Address: Office of the Ombudsman and Administrative Review
Attn: Medicaid Appeals and Reconsiderations
275 East Main Street, 2E-O
Frankfort, KY 40621

Phone: 502-564-5497

Fax: 502-564-9523

The member or his or her representative shall submit a request for a state fair hearing to the CHFS within 120 days of the final appeal decision by Anthem. When a hearing is requested, Anthem will provide to the CHFS and the member, upon request, all Anthem-held documentation related to the Anthem appeal, including but not limited to any transcript(s), records or written decision(s) from participating providers or delegated entities.

An administrative hearing officer of the Cabinet will conduct the state fair hearing. When the hearing is complete, the Director of DOA will report the results of the hearing decision to the member, to Anthem and to CHFS.

Implementation of such a hearing decision shall not be the basis for termination of enrollment by Anthem.

10.3.2 External Review and Administrative Hearing for the Provider

Providers have a right to an external independent third-party review under Kentucky statute. Under Kentucky statute and regulation 907 KAR 17:035, providers have the right to an external, third-party review.

Providers may submit a request for an external independent third party review within 60 calendar days of receiving an MCO's final decision from the MCO's internal appeal process. Provider requests pursuant to 907 KAR 17:035 will not be considered for dates of service prior to 12-1-2016.

The 60-day count shall begin on one of the following dates:

1. Date that the notice was received electronically, if received electronically
2. Date that the notice was received via fax, per the date and time documented on the fax transmission, if the notice was faxed
3. Post mark date on the envelope containing the notice, if the notice was sent via postal mail; an additional three days shall be added when the service is by mail

This request must be submitted to the MCO via one of the contact options designated below. DMS will also post the MCO contact information on their website at chfs.ky.gov/dms. Requests are not accepted verbally. Additional information will not be considered by the third-party reviewer.

Please send your request to one of the following:

- Email: KYExternalReview@anthem.com
- Fax: **502-212-7336**
- Mail: Anthem
Central Appeals Processing
P.O. Box 62429
Virginia Beach, VA 23466-2429
- Electronic: Availity Essentials (Availity.com)

The external review request must include the following actions:

- Identify each specific issue and dispute directly related to the adverse final decision issued by Anthem.
- State the basis on which Anthem's decision on each issue is believed to be erroneous.
- State the provider's designated contact information including name, phone number, mailing address, fax number and email address.
- Clearly indicate **External Independent Review** on the request. This is required in order to ensure appropriate routing to DMS.

The provider will be notified of receipt by Anthem within five business days. Anthem will submit the request with supporting documentation to the Kentucky Department for Medicaid Services (DMS) within 15 business days. The provider will be notified of the final decision within 30 days of receipt or 45 business days if an extension has been agreed to by both parties.

If the external review decision is to overturn the original Anthem decision, the claim will be adjusted within 30 days of the decision.

Following the external review, the party who receives an adverse determination may appeal to DMS and request an Administrative Hearing (state fair hearing) under Kentucky regulation 907 KAR 17:040 within 30 calendar days of receipt of the external review decision letter. The party who receives an adverse final order shall pay a fee of \$600 to DMS for the cost of the Administrative Hearing.

10.4 Continuation of Benefits during Appeals or State Fair Hearings

Anthem is required to continue a member's benefits while the appeals process or the state fair hearing is pending if all of the following are true:

- The request for continuation of benefits is submitted to Anthem on or before the latter of the two:
 - within 10 calendar days of Anthem mailing the notice of action, or
 - the intended effective date of Anthem's proposed 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 original authorization has not expired
- The member requests an extension of benefits

If the decision is against the member, Anthem may recover the cost of the services the member received while the appeal was pending. This process also applies to all EPSDT appeals decisions.

10.5 Payment Adjustment

If provider believes a claim has been improperly adjudicated for covered service for which provider timely submitted a clean claim to plan, provider must submit a request for an adjustment to the plan. Adjustment requests submissions may be denied for payment. The provider shall not be permitted to bill the member for those covered services for which payment was denied.

Chapter 11: Claim Submission Encounters Procedures

11.1 Claims Submission

Claims need to be submitted according to the policies located at providers.anthem.com/ky. Providers have the option of submitting claims electronically to Availity using practice management software/Clearinghouse or by mail.

Anthem encourages providers to submit claims electronically, as providers will be able to:

- Receive payments quickly
- Eliminate paper
- Save money

Providers must submit all claims on a CMS-1500 or CMS-1450/UB-04 claim form or its successor form(s) as applicable based on the services provided in accordance with claims reporting requirements. Provider must report all health services in accordance with the Coded Service Identifier(s) reporting guidelines and instructions using *HIPAA* compliant billing codes. In addition, Anthem shall not pay any claim(s) nor accept any encounter data submitted using non-compliant codes. Anthem audits that result in identification of health services that are not reported in accordance with the Coded Service Identifier(s) guidelines and instructions, will be subject to recovery through remittance adjustment or other recovery action.

11.2 Electronic Submissions

Availity is our exclusive partner for managing all Electronic Data Interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (835) allows for a faster, more efficient, and cost-effective way for providers to do business.

Use Availity for the following EDI transactions

- Healthcare Claim: Professional (837P)
- Healthcare Claim: Institutional (837I)
- Healthcare Eligibility Benefit Inquiry and Response (270/271)
- Healthcare Services Prior Authorization (278)
- Healthcare Services Inpatient Admission and Discharge Notification (278N)
- Healthcare Claim Payment/Advice (835)
- Healthcare Claim Status Request and Response (276/277)
- Medical Attachments (275)

Availity's EDI submission Options

EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software). To register for direct EDI transmissions, visit – Availity.com > Provider Solutions > EDI Clearinghouse. Use your existing vendor for your EDI transactions (work with your vendor to ensure connection to the Availity EDI Gateway/EDI Response Reports).

Claims submitted electronically will return response reports that may contain rejections. If using a Clearinghouse or Billing Vendor, please work with them to ensure you are receiving all reports. It's

important to review rejections on the response reports. Rejections will not continue through the process and require correction and resubmission. For questions on electronic response reports contact your Clearinghouse or Billing Vendor or Availity if you submit directly using your practice management software at **800- AVAILITY (800-282-4548)**.

Availity EDI Payer IDs

Payer IDs ensure your EDI submissions are routed correctly when received by Availity.

Claim Payer IDs:

- Professional ID is 00660
- Institutional ID is 00160

Note: If you use a clearinghouse, billing service or vendor, please work with them directly to determine payer ID.

Electronic Remittance Advice (ERA)

The 835 Electronic Remittance Advice eliminates the need for paper remittance reconciliation.

Use Availity to register and manage ERA account changes with these three easy steps:

- Log in to **Availity apps** [Availity.com/availity/web/public.elegant.login](https://www.availity.com/availity/web/public.elegant.login)
- Select **My Providers**
- Select **Enrollment Center** and select **Transaction Enrollment**

Note: If you use a clearinghouse or vendor, please work with them on ERA registration and receiving your ERAs.

Electronic Funds Transfer (EFT)

Electronic claims payment through electronic funds transfer (EFT) is a secure and fastest way to receive payment reducing administrative processes. EFT deposit is assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.

Use EnrollSafe (enrollsafe.payeehub.org/) to register and manage EFT account changes.

EDI Submission for Corrected Claims

For corrected electronic claims use one the following frequency codes:

- 7 – Replacement of Prior Claim
- 8 – Void/Cancel Prior Claim

EDI segments required:

- Loop 2300- CLM - Claim frequency code
- Loop 2300 - REF - Original claim number

Note: Please work with you vendor on how to submit corrected claims or contact Availity Client Services.

Useful EDI Documentation

- **Availity EDI Connection Service Startup Guide** – This guide includes information to get you started with submitting Electronic Data Interchange (EDI) transactions to Availity, from registration to on-going support.
- **Availity EDI Companion Guide** – This Availity EDI Guide supplements the *HIPAA* TR3s and describes the Availity Health Information Network environment, interchange requirements, transaction responses, acknowledgements, and reporting for each of the supported transactions as related to Availity.
- **Availity Registration Page** – Availity register page for users new to Availity.
- **Anthem EDI Companion Guide** – This guide includes payer specific details for submitting electronic claims.

Contact Availity

Please contact Availity Client Services with any questions at **800-AVAILITY (282-4548)**.

11.3 Web-based Claims Submissions

Providers can also submit single claims through Availity Essentials. From the home screen under Claims & Payments select Professional or Institutional Claim & complete online claim form. Providers have the option to submit corrected claims and attachments using the Availity web claim submission.

11.4 Paper Claim Submission

Providers must submit a properly completed CMS-1450 or CMS-1500 (02-12) claim form according to Anthem's submission policies located at providers.anthem.com/ky. Submit paper claims to:

Kentucky Claims
 Anthem
 P.O. Box 61010
 Virginia Beach, VA 23466-1010

CMS-1500 and CMS-1450 forms are available from the Centers for Medicare & Medicaid Services at cms.hhs.gov.

11.5 International Classification of Diseases, 10th Revision (ICD-10) 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 healthcare settings.

Although Anthem often uses 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.

11.6 Claims Adjudication

Anthem is dedicated to providing timely adjudication of claims. Anthem processes all claims according to generally accepted claims coding and payment guidelines defined by the CPT-4 and ICD-10 manuals.

The provider must use *HIPAA*-compliant billing codes when billing Anthem electronically or on paper. When billing codes are updated, the provider is required to use appropriate replacement codes for submitted claims. Anthem will reject claims submitted with noncompliant billing codes.

Anthem reserves the right to use code-editing software to determine which services is considered part of, incidental to or inclusive of the primary procedure.

Whether the provider submits claims through EDI or on paper, use Anthem's claims guide charts to ensure the provider submits clean and complete claims; found at providers.anthem.com/ky.

11.7 Timely Filing

Effective January 1, 2021, paper and electronic claims must be received within 365 calendar days of the date of discharge for inpatient services and date of service for outpatient services, unless otherwise specified in a provider's contract.

There are exceptions to the timely filing requirements. These include:

- Cases of coordination of benefits/subrogation. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date of the third party's resolution of the claim.
- Cases where a member has retroactive eligibility. In situations of enrollment in Anthem with a retroactive eligibility date, the time frames for filing a claim will begin on the date that Anthem receives notification from the enrollment broker of the member's eligibility/enrollment.

Anthem will reconsider reimbursement of a claim that is denied for failure to meet timely filing requirements when a provider can:

- Provide a date of claim receipt compliant with applicable timely filing requirements or
- Demonstrate "good cause" exists.

Please see additional details found in Anthem's submission policies located at providers.anthem.com/ky.

11.8 Clean Claims Payments

A clean claim is a request for payment for a service rendered by a provider that:

- Is submitted on time

- Is accurate
- Is submitted on a *HIPAA*-compliant standard claim form (CMS-1500 or CMS-1450 or successor forms)
- Requires no further information, adjustment or alteration to be processed and paid
- Is not from a provider who is under investigation for fraud or abuse
- Is not a claim under review for medical necessity

Anthem will adjudicate clean claims to a paid or denied status within 30 calendar days of receipt. Claims related to organ transplant will be paid within 60 calendar days of receipt. If Anthem does not pay the claim within these time frames, Anthem will pay all applicable interest as required by law.

Anthem produces and mails a remittance on a twice a week basis. It shows the status of each claim that has been adjudicated during the previous claim cycle.

If Anthem does not receive all of the required information, Anthem will deny the claim either in part or in whole within 30 calendar days of receipt of the claim or 60 calendar days for transplant claims. A request for the missing information will appear on the provider's remit.

Once Anthem has received the requested information, Anthem will process the claim within 30 calendar days.

Anthem will return paper claims that are determined to be unclean along with a letter stating the reason for the rejection. Anthem will return electronic claims that are determined to be unclean to the clearinghouse that submitted the claim.

Anthem provides to each Medicaid Provider the opportunity for an in-person meeting with a representative of the Contractor on any clean claim that remains unpaid in violation of *KRS 304.17A-700* to *304.17A-730* and on any claim that remains unpaid for forty-five (45) days or more after the date on which the claim is received by the Contractor and that individually, or in the aggregate, exceeds \$2,500.

11.8.1 Prepayment review

Anthem routinely conducts reviews of members' medical records to ensure accuracy of provider payments. Compliance with requests to submit medical records is a standard component of our provider contracts. Anthem's prepayment review program evaluates medical records and validates services are billed appropriately. This process does not impact timely adjudication of claims submitted with supporting medical records. Under the prepayment review program, Anthem will review all claims billed under identified codes prior to processing the claim to determine the appropriateness of the claim. Prepayment review includes any and all existing and future NPIs and TINs associated with the practice. If a provider is placed under pre-payment review, a letter will be issued prior to the effective date outlining the specifics of the review. The following guidelines apply to the program:

1. Provider will be given 45 calendar days to submit documents in support of claims under prepay review. Claims will be denied if the requested documentation is not received by day 46.
2. Anthem will deny a claim if the submitted documentation lacks evidence to support the billed service or code.
3. Provider may appeal a denied claim within the proper timely filing guidelines as outlined in Sections 10.4 and 10.5 of this provider manual.
4. If the provider has sustained a 90 percent error-free claims submission rate to Anthem for 45 calendar days, the provider may be removed from the prepayment review process or Anthem

will request permission from the Department for Medicaid Services to continue the prepayment review when it is determined necessary to prevent improper payments.

11.9 Claims Status

Providers can check the status of claims using Availity Essentials at providers.anthem.com/ky or Availity.com.

From Availity Essentials home page, select Claims & Payments > Claim Status. Provider can also access Chat with Payer through Availity Payer Space. When viewing the status of a claim on Availity, there may be options available to submit medical records, itemized bills or dispute the claim. Provider can also call Anthem's Provider Services team at **855-661-2028**.

If Anthem does not have the claim on file, resubmit claims within the timely filing requirements. If filing electronically, check the EDI response reports for acceptance of the claim received from your EDI vendor or clearinghouse.

11.10 Coordination of Benefits, Third-party Liability and Blue Card Association

Anthem follows Kentucky state-specific guidelines when coordination of benefits is necessary. Anthem uses covered medical and hospital services whenever available or other public or private sources of payment for services rendered to Anthem members.

When third-party resources and Third-Party Liability (TPL) resources are available to cover the costs of trauma-related claims and medical services provided to Medicaid members, Anthem will reject the claim and redirect members to bill the appropriate insurance carrier (unless certain pay and chase circumstances apply — see below). Or, if Anthem does not become aware of the resource until after payment for the service was rendered, Anthem will pursue post-payment recovery of the expenditure. Providers must not seek recovery in excess of the Medicaid payable amount.

The pay and chase circumstances are:

- When the services are for preventive pediatric care, including EPSDT
- If the claim is for prenatal or postpartum care or if service is related to OB care
- For any service rendered to a child of an absent parent (i.e., primary coverage is through a noncustodial parent after a divorce)

Anthem's subrogation vendor handles the filing of liens and settlement negotiations both internally and externally.

If providers have any questions regarding paid, denied or pended claims, please call Provider Services at **855-661-2028**.

11.11 Reimbursement Policies

Reimbursement policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if Anthem covered the service for the member's benefit plan. 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. These codes denote the services and/or procedures performed and, when , must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. [Brand] strives to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

11.11.1 Reimbursement Hierarchy

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



11.11.2 Review Schedule and Updates

Reimbursement Policies undergo reviews for updates to state contracts, federal or CMS requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to an Anthem business decision. We reserve the right to review and revise our policies when necessary. When there is an update, we will publish the most current policies to our provider website.

Medical Coding

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

- Correct modifier use.
- Effective date of transaction code sets (CPT, HCPCS, Service Encounter Reporting Instructions (SERI), ICD-10 diagnosis/procedures, revenue codes, etc.).
- Code editing rules appropriately applied and within regulatory requirements.
- Analysis of codes, code definition and appropriate use.

11.11.3 Reimbursement by Code Definition

Anthem allows reimbursements for covered services based on their procedure code definitions or descriptors, unless otherwise noted by state or provider contracts, or state, federal or CMS requirements. There are eight 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 codes: temporary codes for emerging technology, services or procedures

11.11.4 Outlier Reimbursement – Audit and Review Process

Requirements and Policies

This section includes guidelines on reimbursement to Providers and Facilities for services on claims paid by DRG with an outlier paid at percent of billed charge or where the entire claim is paid at percent of billed charge. Our vendor-partner or our internal team may review these claims as part of our itemized bill review (IBR) program to ensure appropriate reimbursement. Upon completion of the review, documentation, including a summary of adjusted charges, will be provided for each claim. Disputes related to the review may be submitted according to the instructions in the Claims Payment Disputes section of this manual.

In addition to any header in this section, please refer to all other service specific sections which may have more stringent guidelines. There may be multiple sections that apply to any given reimbursable service.

Audits/Records Requests

At any time, a request may be made for on-site, electronic or hard copy medical records, utilization review documentation and/or itemized bills related to Claims for the purposes of conducting audit or reviews.

Blood, and Blood Products

Administration of Blood or Blood Products are not separately reimbursable on inpatient claims. Administration charges on outpatient claims are separately reimbursable when submitted without observation/treatment room charges.

Charges for blood storage and processing, thawing fees charges, irradiation, and other processing charges, are also not separately reimbursable.

Emergency Room Supplies and Services Charges

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

Facility Personnel Charges

Charges for Inpatient Services for Facility personnel are not separately reimbursable and the reimbursement for such is included in the room and board rate. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions (including IV or PICC line insertion at bedside), professional therapy functions, including Physical, Occupational, and Speech call back charges, nursing increments, therapy increments, and bedside respiratory and pulmonary function services. Charges for Outpatient Services for facility personnel are also not separately reimbursable. The reimbursement is included in the payment for the procedure or Observation charge.

Implants

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

Staples, sutures, clips, as well as temporary drains, tubes, similar temporary medical devices and supplies shall not be considered implants. Implants that are deemed contaminated and/or considered waste and/or were not implanted in the Member will not be reimbursed.

IV Sedation and Local Anesthesia

Charges for IV sedation and local anesthesia administered by the provider performing the procedure, and/or nursing personnel, is not separately reimbursable and is included as part of the Operating Room ("OR") time/procedure reimbursement. Medications used for IV sedation and local anesthesia are separately reimbursable.

Lab Charges

The reimbursement of charges for specimen collection are considered facility personnel charges and the reimbursement is included in the room and board or procedure/Observation charges. Examples include venipuncture, urine/sputum specimen collection, draw fees, phlebotomy, heel sticks, and central line draws.

Processing fees, handling fees, and referral fees are considered included in the procedure/lab test performed and not separately reimbursable.

Labor Care Charges

Reimbursement will be made for appropriately billed room and board or labor charges. Payment will not be made on both charges when billed concurrently.

Nursing Procedures

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

Operating Room Time and Procedure Charges

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

- The use of the operating room
- The services of qualified professional and technical personnel

Personal Care Items and services

Personal care items used for patient convenience are not separately reimbursable. Examples include but are not limited to: breast pumps, deodorant, dry bath, dry shampoo, lotion, non-medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, toothbrush and toothpaste, bedpans, chux, hot water bottles, icepacks, pillows, sitz baths, and urinals.

Pharmacy Charges

Reimbursement will be made for the cost of drugs prescribed by the attending physician. Additional separate charges for the administration of drugs, the cost of materials necessary for the preparation and administration of drugs, and the services rendered by registered pharmacists and other pharmacy personnel will not be reimbursed separately. All other services are included in the drug reimbursement rate. Example of pharmacy charges which are not separately reimbursable include, but are not limited to: IV mixture fees, IV diluents such as saline and sterile water, IV Piggyback (IVPB), Heparin and saline flushes to administer IV drugs, and facility staff checking the pharmacy ("Rx") cart.

Portable Charges

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

Pre-Operative Care or Holding Room Charges

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

Preparation (Set-Up) Charges

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

Recovery Room Charges

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

Recovery Room services related to IV sedation and/or local anesthesia

Separate reimbursement will not be made for a phase I or primary recovery room charged in connection with IV sedation or local anesthesia. Charges will be paid only if billed as a post procedure room or a phase II recovery (step-down) Examples of procedures include arteriograms and cardiac catheterization.

Supplies and Services

Items used for the patient which are needed as a direct result of a procedure or test are considered part of the room and board or procedure charges and are not separately reimbursable.

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

Special Procedure Room Charge

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

Stand-by Charges

Standby equipment and consumable items which are on standby, are not reimbursable. Standby charges for facility personnel are included in the reimbursement for the procedure and not separately reimbursable.

Stat Charges

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

Supplies and Equipment

Charges for medical equipment, including but not limited to, IV pumps, PCA Pumps, and isolation carts and supplies are not separately reimbursable.

In addition, oxygen charges, including but not limited to, oxygen therapy per minute/per hour, mechanical ventilation and ventilation management, continuous positive airway pressure (CPAP), and bi-level positive airway pressure (BIPAP), when billed with room types ICU/CCU/ NICU or any Specialty Care area, where equipment is a requirement to be authorized for specialty category, are not separately reimbursable.

Telemetry

Telemetry charges in ER/ ICU/CCU/NICU or telemetry unit (step-down units) are included in the reimbursement for the place of service. Additional monitoring charges are not reimbursable.

Time Calculation

- **Operating Room ("OR")** – Time should be calculated on the time the patient enters the room until the patient leaves the room, as documented on the OR nurse’s notes.
- **Hospital/ Technical Anesthesia** – Reimbursement of technical anesthesia time will be based on the time the patient enters the operating room (OR) until the patient leaves the room, as documented on the OR nurse’s notes. The time the anesthesiologist spends with the patient in pre-op and the recovery room will not be reimbursed as part of the hospital anesthesia time.
- **Recovery Room** – The reimbursement of Recovery Room charges will be based on the time the patient enters the recovery room until the patient leaves the recovery room as documented on the post anesthesia care unit ("PACU") record.
- **Post Recovery Room** – Reimbursement will be based on the time the patient leaves the Recovery Room until discharge.

Video or Digital Equipment used in Operating Room

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

Additional Reimbursement Guidelines for Disallowed Charges

The disallowed charges (charges not eligible for reimbursement) include, but are not limited to, the following, whether billed under the specified Revenue Code or any other Revenue Code. These Guidelines may be superseded by your specific agreement. Please refer to your contractual fee schedule for payment determination.

The tables below illustrate examples of non-reimbursable items/services codes.

Examples of non-reimbursable items/services codes	
Typically billed under this/these revenue codes but not Limited to the revenue codes listed below	Description of excluded items
0990 – 0999	Personal Care Items Courtesy/Hospitality Room Patient Convenience Items (0990) Cafeteria, Guest Tray (0991) Private Linen Service (0992) Telephone, Telegraph (0993) TV, Radio (0994) Non-patient Room Rentals (0995) Beauty Shop, Barber (0998) Other Patient Convenience Items (0999)
0220	Special Charges
0369	Preoperative Care or Holding Room Charges

Examples of non-reimbursable items/services codes	
Typically billed under this/these revenue codes but not Limited to the revenue codes listed below	Description of excluded items
0760 – 0769	Special Procedure Room Charge
0111 – 0119	Private Room* (subject to Member’s Benefit)
0221	Admission Charge
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) Stand-by Charges
0220, 0949	Stat Charges
0270 – 0279, 0360	Video Equipment Used in Operating Room
0270, 0271, 0272	<p>Supplies and Equipment</p> <p>Blood Pressure cuffs/Stethoscopes Thermometers, Temperature Probes, etc. Pacing Cables/Wires/Probes Pressure/Pump Transducers Transducer Kits/Packs SCD Sleeves/Compression Sleeves/Ted Hose Oximeter Sensors/Probes/Covers Electrodes, Electrode Cables/Wires Oral swabs/toothettes; Wipes (baby, cleansing, etc.) Bedpans/Urinals Bed Scales/Alarms Specialty Beds Foley/Straight Catheters, Urometers/Leg Bags/Tubing Specimen traps/containers/kits Tourniquets Syringes/Needles/Lancets/Butterflies Isolation carts/supplies Dressing Change Trays/Packs/Kits Dressings/Gauze/Sponges Kerlix/Tegaderm/OpSite/Telfa Skin cleansers/preps Cotton Balls; Band-Aids, Tape, Q-Tips Diapers/Chucks/Pads/Briefs Irrigation Solutions ID/Allergy bracelets Foley stat lock Gloves/Gowns/Drapes/Covers/Blankets Ice Packs/Heating Pads/Water Bottles Kits/Packs (Gowns, Towels and Drapes) Basins/basin sets</p>

Examples of non-reimbursable items/services codes	
Typically billed under this/these revenue codes but not Limited to the revenue codes listed below	Description of excluded items
	Positioning Aides/Wedges/Pillows Suction Canisters/Tubing/Tips/Catheters/Liners Enteral/Parenteral Feeding Supplies (tubing/bags/sets, etc.) Preps/prep trays Masks (including CPAP and Nasal Cannulas/Prongs) Bonnets/Hats/Hoods Smoke Evacuator Tubing Restraints/Posey Belts OR Equipment (saws, skin staplers, staples & staple removers, sutures, scalpels, blades etc.) IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets, transducers, fluid warmers, heparin and saline flushes, etc.)
0220 – 0222, 0229, 0250	Pharmacy Administrative Fee (including mixing meds) Portable Fee (cannot charge portable fee unless equipment is brought in from another Facility) Patient transport fees
0223	Utilization Review Service Charges
0263	IV Infusion for therapy, prophylaxis (96365, 96366) IV Infusion additional for therapy IV Infusion concurrent for therapy (96368) IV Injection (96374, 96379)
0230, 0270 – 0272, 0300 – 0307, 0309, 0390 – 0392, 0310	Nursing Procedures
0230	Incremental Nursing – General
0231	Nursing Charge – Nursery
0232	Nursing Charge – Obstetrics (OB)
0233	Nursing Charge – Intensive Care Unit (ICU)
0234	Nursing Charge – Cardiac Care Unit (CCU)
0235	Nursing Charge – Hospice
0239	Nursing Charge – Emergency Room (ER) or Post Anesthesia Care Unit (PACU) or Operating Room (OR)

Examples of non-reimbursable items/services codes	
Typically billed under this/these revenue codes but not Limited to the revenue codes listed below	Description of excluded items
0250 – 0259, 0636	Pharmacy (non-formulary drugs, compounding fees, nonspecific descriptions) Medication prep Nonspecific descriptions Anesthesia Gases – Billed in conjunction with Anesthesia Time Charges IV Solutions 250 cc or less, except for pediatric claims Miscellaneous Descriptions Non-FDA Approved Medications
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	Specimen collection Draw fees Venipuncture Phlebotomy Heel stick Blood storage and processing blood administration (Rev codes 0380, 0390 – 0392; 0399) Thawing/Pooling Fees
0270, 0272, 0300 – 0309	Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time, glucose, etc.)
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0410, 0460	Supplies and Equipment Oxygen (ICU/CCU/Progressive) O.R., ER and Recovery Instrument Trays and/or Surgical Packs Drills/Saws (All power equipment used in O.R.) Drill Bits Blades IV pumps and PCA (Patient Controlled Analgesia) pumps Isolation supplies Daily Floor Supply Charges X-ray Aprons/Shields Blood Pressure Monitor Beds/Mattress Patient Lifts/Slings Restraints Transfer Belt Bair Hugger Machine/Blankets SCD Pumps Heel/Elbow Protector Burrs Cardiac Monitor EKG Electrodes

Examples of non-reimbursable items/services codes	
Typically billed under this/these revenue codes but not Limited to the revenue codes listed below	Description of excluded items
	Vent Circuit Suction Supplies for Vent Patient Electrocautery Grounding Pad Bovie Tips/Electrodes Anesthesia Supplies Case Carts C-Arm/Fluoroscopic Charge Wound Vacuum Pump Bovie/Electro Cautery Unit Wall Suction Retractors Single Instruments Oximeter Monitor CPM Machines Lasers Da Vinci Machine/Robot
0370 – 0379, 0410, 0460, 0480 – 0489	Anesthesia Nursing care Monitoring Intervention Pre- or Post-evaluation and education IV sedation and local anesthesia if provided by RN Intubation/Extubation CPR
0410	Respiratory Functions: Oximetry reading by nurse or respiratory Respiratory assessment/vent management Medication Administration via Nebs, Metered dose (MDI), etc. Charges Postural Drainage Suctioning Procedure Respiratory care performed by RN
0940 – 0945	Education/Training

11.12 Billing Members

Before rendering a service that is not covered by Anthem, inform the Anthem member that Anthem does not cover the cost of the service; he or she will have to pay for the service. Pursuant to Section 1128B(d)(1) 42 U.S.C. 1320a-7b of the *Social Security Act*, a provider who knowingly and willfully bills a member for a Medicaid Covered Service may be convicted of a felony and be subject to fines and/or imprisonment.

There may be limited circumstance when a member maybe permitted to choose to self-pay. For verification in those circumstances, contact provider services at **855-661-2028**.

If providers choose to provide services that Anthem does not cover:

- Understand that Anthem only reimburses for services that are medically necessary, including hospital admissions and other services
- Understand that providers may not bill for or take recourse against a member for denied or reduced claims for services that are within the amount, duration and scope of benefits of the Medicaid program

Providers cannot balance-bill for the amount above that which Anthem pays for covered services.

In addition, providers may not bill a member if any of the following occurs:

- Failure to submit a claim on time, including claims not received by Anthem
- Failure to submit a claim to Anthem for initial processing within the timely filing deadline for providers
- Failure to dispute a corrected claim within the clean-claim submission period
- Failure to appeal a claim within the 90-day payment dispute period
- Failure to appeal a utilization review determination within 60 days of notification of coverage denial
- Submission of an unsigned or otherwise incomplete claim
- Errors made by provider in claims preparation, claims submission or the appeal/dispute process

11.13 Client Acknowledgment Statement

"If a member agrees in advance in writing to pay for a non-Medicaid covered service, then the contractor, the contractor's provider, or contractor's subcontractor may bill the member. The standard release form signed by the member at the time of services does not relieve the contractor, providers and subcontractors from the prohibition against billing a Medicaid member in the absence of a knowing assumption of liability for a non-Medicaid covered service. The form or other type of acknowledgement relevant to Medicaid member liability must specifically state the services or procedures that are not covered by Medicaid."

"I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under Anthem as being reasonable and medically necessary for my care or are not a covered benefit. I understand that Anthem has established the medical necessity standards for the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined to be inconsistent with the Anthem medically necessary standards for my care or are not a covered benefit."

Signature: _____

Date: _____

11.14 Garnishment

In accordance with the Medicaid Managed Care Contract with the Commonwealth of Kentucky, Section 37.0, DMS may request that a Medicaid managed care organization (MCO) collect from future provider payments to satisfy the provider's outstanding balance with DMS. Recoveries will not always be

assigned to one MCO. If the provider is participating with only one MCO, then the recovery letter will be sent to that MCO. The provider will not be able to avoid repayment by switching MCOs. If the provider is participating with multiple MCOs and has a large Medicaid receivable, then all MCOs will be notified to recover on Medicaid's behalf. Recoveries are to continue until the outstanding amount has been collected or until the MCO is notified by DMS.

Appendix A: Forms

The following is a sample of forms available for download at providers.anthem.com/ky.
To request hard copies of these forms, please call Anthem Provider Services team at **855-661-2028**.

Do Not Resuscitate (DNR) Order

chfs.ky.gov/agencies/dail/Documents/InstructionsForDAILDNR01.pdf

Provider Correspondence and Appeals

- *Claim Payment Appeals Submission Form*
- *Claim Correspondence Form*

Referral and Claim Submissions

- *Prior Authorization Request*
- *Maternity Notification*
- *CMS-1500 (02-12)*
- *CMS-1450*

Provider Services: **855-661-2028**
<https://providers.anthem.com/ky>



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