

Provider Manual

Anthem Blue Cross and Blue Shield Healthcare Solutions
Medicaid Managed Care



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How to apply for participation

If you are interested in joining our network, please see our website:

<https://providers.anthem.com/nevada-provider/join-our-network>

If you need additional assistance, contact Provider Services at **844-396-2330**.

<https://collaborate.wellpoint.com/sites/MedicaidCompliancePM/LA47607/SitePages/Home.aspx>

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1 INTRODUCTION

Welcome to the Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem) network! We are pleased you have joined our network, which represents some of the finest healthcare providers in the state.

Anthem is a licensed managed care organization (MCO). We bring national expertise in operating local, community-based healthcare plans with experienced local staff to complement our operations. We are committed to assisting you in providing quality healthcare.

We believe hospitals, physicians and other providers play pivotal roles in managed care. We can only succeed by working collaboratively with you and other caregivers. Earning your loyalty and respect is essential to maintaining our stable, high-quality provider network. All network providers are contracted with us through a *Participating Provider Agreement*.

If you are interested in participating in any of our quality improvement committees or learning more about specific policies, please contact us. Most committee meetings are scheduled at times and locations intended to be convenient for you. Please call Provider Services at **844-396-2330** with any suggestions, comments, or questions. Together, we can arrange for and provide an integrated system of coordinated, efficient and quality care for our members and your patients.

We retain the right to add to, delete from and otherwise modify this provider manual. Contracted providers must acknowledge this provider manual and any other written materials we provide as proprietary and confidential.

Please note: Material in this provider manual is subject to change. Please go to <https://providers.anthem.com/nv> for the most up-to-date information.

2 OVERVIEW

2.1 Who is Anthem Blue Cross and Blue Shield Healthcare Solutions?

Community Care Health Plan of Nevada, Inc., doing business as Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem), is a leader in managed healthcare services for the public sector. We provide healthcare coverage exclusively to low-income families, children, pregnant women, and the expansion population.

We operate a community-focused managed care company with an emphasis on the public sector healthcare market. We coordinate our members' physical and behavioral healthcare, offering a continuum of education, access, care, and outcome programs, resulting in lower cost, improved quality, and better health status for Americans.

2.2 Strategy

Our strategy is to:

- Improve access to preventive primary care services by ensuring the selection of a primary care provider (PCP) who will serve as provider, care manager and coordinator for all basic medical services.
- Improve health status of and outcomes for members.
- Educate members about their benefits, responsibilities, and the appropriate use of healthcare services.
- Encourage stable, long-term relationships between providers and members.
- Encourage medically appropriate use of specialists and emergency rooms.
- Commit to community-based enterprises and community outreach.
- Facilitate the integration of physical and behavioral healthcare.
- Foster quality improvement mechanisms that actively involve providers in re-engineering healthcare delivery.
- Encourage a customer service orientation with regular measurement of member and provider satisfaction.

2.3 Summary

Escalating healthcare costs are driven in part by a pattern of fragmented episodic care and, quite often, unmanaged health problems of members. We strive to educate members to encourage the appropriate use of the managed care system and to be involved in all aspects of their healthcare.

3 QUICK REFERENCE INFORMATION

3.1 Our Website

Our website contains a full complement of provider resources, including an online provider inquiry tool for real-time eligibility, claims status and authorization status. In addition, the website provides helpful information such as forms, the *Preferred Drug List*, drugs requiring prior authorization, provider manuals, referral directories, provider newsletters, claims status, electronic remittance advice and electronic funds transfer information, updates, clinical guidelines, and other information to help you work with us. Visit our site at <https://providers.anthem.com/nv>.

Call Provider Services for precertification/notification, health plan network information, member eligibility, claims information, inquiries, and recommendations you may have about improving our processes and managed care program.

3.2 Anthem Phone Numbers

Provider Services: **844-396-2330** (TTY **711**), This same number is used for:

- The Automated Member Eligibility Line
- Pharmacy Services
- And more

24/7 NurseLine: **844-396-2329** (TTY **711**)

Member Services: **844-396-2329** (TTY **711**)

Vision Services — EyeQuest: **855-230-4656**

Radiology Services — Carelon Medical Benefits Management, Inc.:* **833-419-2139**

Carelon Behavioral Health, Inc.* National Provider Service Line — **800-397-1630** Monday through Friday, 5 a.m. to 5 p.m. Pacific time

Electronic Data Interchange (EDI) — **800-Availity (282-4548)**

Nonemergency Transportation — MTM: **844-879-7341** (for Medicaid members only)

3.3 Nevada Phone Numbers

Nevada Department of Health Care and Financing Policy Medicaid Office: **775-684-3600**

Nevada Medicaid Customer Service Center: **877-638-3472**

3.4 Additional Quick Reference Info

Keeping the Door Open with Ongoing Communications

To make sure you have the information you need to work effectively with us and our members, we will send you broadcast faxes, notify you of provider manual updates, mail you quarterly newsletters and post information on our website. Keep reading for more information to help you in your day-to-day interaction with us.

Additional Information	
Administrative Denials and Administrative Appeals	<ul style="list-style-type: none"> • An administrative denial is a denial of services that is based on reasons other than medical necessity. • Administrative denials are made when a contractual requirement is not met, such as late notification of admissions or lack or precertification. • If you are dissatisfied with an administrative denial decision, you may file an administrative appeal by submitting a written request with supporting documentation as to why the administrative requirements were met. • An administrative appeal must be filed within 60 calendar days of the date on the administrative denial notice. • We will render a decision and send a determination letter within 30 calendar days of receiving the administrative appeal. • Administrative appeals are eligible for one level of appeal. • Administrative appeals can be submitted through the Availity Essentials website: https://www.availity.com. • Submit an administrative appeal to: Anthem Blue Cross and Blue Shield Healthcare Solutions Appeals Department P.O. Box 62429 Virginia Beach, VA 23466-2429 •
Claims Information	<p>Filing your claims should be simple. That is why Anthem Blue Cross and Blue Shield Healthcare Solutions uses Availity, a secure and full-service website that offers a claims clearinghouse and real-time transactions at no charge to healthcare professionals. You can use Availity to submit and check the status of all your claims and much more at www.availity.com.</p> <p>Timely Filing Limits:</p> <ul style="list-style-type: none"> • 180 days from the date of service to submit a clean claim (unless otherwise stated in the provider agreement) • Out of state and emergency transportation: 365 days from the last date of service • If other health insurance exists: 180 days from the date of the Explanation of Payments (EOP) for in-network/participating providers (365 days from the EOP for out of state providers) • Level One Claim Dispute: 90 days from the date of the EOP • Level Two Claim Dispute: 30 days from the date of the Level One reconsideration decision letter/ correspondence <p>Submit claims:</p>

- **Submit using Availity:**
 1. From the Availity home page, select **Claims & Payments** from the top navigation.
 2. Select **Type of Claim** from the drop-down menu.
- **Submit electronically through a clearinghouse or use your practice management software:**
 1. Anthem BCBS Nevada Payer ID: 00265
 2. For a full list please visit Availity.com:
<https://apps.availity.com/public-web/payerlist-ui/payerlist-ui/#/>
 3. Note: If you use a clearinghouse, billing service or vendor, please work with them directly to determine payer ID.
- **Submit paper claims:**
 1. Mail claims to:
Anthem Blue Cross and Blue Shield Healthcare Solutions
Nevada Claims
P.O. Box 61010
Virginia Beach, VA 23466-1010

Claims status inquiry

- Check status directly in Availity:
- You can check the status of a claim anytime by logging in to Availity Essentials at <https://www.availity.com> and selecting **Claims & Payments > Claim Status** Call Provider Services: **844-396-2330**

Clear Claims Connection

Our Clear Claims Connection tool is available to help you review procedure code edits and receive edit rationale. **Before disputing a claim**, be sure to use this tool to help reduce the number of disputes you must file.

1. From the Availity home page, select **Payer Spaces** from the top navigation.
2. Select the health plan.
3. From the *Payer Spaces* home page, select the **Applications** tab.
4. Select the **Clear Claims Connection** tile.

Claims dispute (Level One):

To dispute a claim:

1. From the Availity home page, select **Claims & Payments** from the top navigation.
2. Select **Claim Status** from the drop-down menu.
3. Submit an inquiry and review the *Claims Status Detail* page.
4. If the claim is denied or final, there may be an option to dispute the claim. Select **Dispute the Claim** to initiate the process. Navigate to **Claims & Payments** then select **Appeals**. Locate your initiated dispute, upload your documentation, and submit. If you have questions on a claim, you may also:
 - Call Provider Services: **844-396-2330**
 - Use the **Chat with Payer** or **Secure Messaging** features located on the Claim Status screen.

Claim Appeal (Level Two):

1. A Second Level Claim Payment Appeal must be received within 30 calendar days from the date of the first level decision/resolution letter
2. **Option 1: Using Availity:**
 - a. Locate the claim you want to dispute on Availity using Claim Status from the **Claims & Payments** menu. If available, select Dispute Claim to initiate the dispute. Go to *Request* to navigate directly to the initiated dispute in the appeals dashboard add the documentation and submit.
3. **Option 2: Mailing a Written Appeal:**
 - a. A written Claim Payment Appeal request can be mailed to the following address:

Anthem Payment Disputes
Payment Dispute Unit
P.O. Box 61599
Virginia Beach, VA 23466-1599
 - b. The request must include supporting documentation such as an *EOP* or other written explanation along with the copy of the claim.
 - c. If not accompanied by a full explanation the claim may be returned and not accepted as a reconsideration.

Submit your attachments a few different ways:

1. Submit a PWK segment with your electronic claim and either submit documentation using the EDI 275 transaction or by going to availity.com > Claim & Payments > Claims > Attachment New. Locate your PWK intake in the Attachment New Dashboard inbox and upload your documentation. *The PWK intake will be available for 7 calendar days.*
2. Locate your claim using Availity Essentials Claim Status by navigating to Claims & Payments > Claim Status > Select Attachment button and upload your documents. You can view the status of the attachment by navigating to Claims & Payments > Attachment New.
3. Submit an online claim submission using Availity Essentials. Navigate to Claims & Payments > select Professional or Institutional claim > attach your documentation directly to the online claim form.

<p>Electronic Data Interchange (EDI)</p>	<p>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.</p> <p>Use Availity for the following EDI transactions:</p> <ul style="list-style-type: none"> • 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) <p>Availity's EDI submission Options:</p> <ul style="list-style-type: none"> • 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 Clearinghouse for your EDI transactions (work with your vendor to ensure connection to the Availity EDI Gateway) <p>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.</p> <p>Availity EDI Payer ID – 00265</p> <p>Electronic Remittance Advice (ERA) The 835 eliminates the need for paper remittance reconciliation. Use Availity to register and manage ERA account changes with these three easy steps:</p> <ul style="list-style-type: none"> • Log in to Availity https://apps.availity.com/availity/web/public.elegant.login • Select My Providers • Select Enrollment Center and select Transaction Enrollment <p>Note: If you use a clearinghouse or vendor, please work with them on ERA registration and receiving your ERA's.</p> <p>EDI Submission for Corrected Claims For corrected electronic claims use one the following frequency codes:</p> <ul style="list-style-type: none"> • 7 – Replacement of Prior Claim • 8 – Void/Cancel Prior Claim
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	<p>EDI segments required:</p> <ul style="list-style-type: none"> • Loop 2300- CLM - Claim frequency code • Loop 2300 - REF - Original claim number <p>Please work with you vendor on how to submit corrected claims.</p>
<p>Electronic funds transfer (EFT)</p>	<p>Electronic claims payment through electronic funds transfer (EFT) is a secure and fast way to receive payment, reducing administrative processes. EFT deposits are assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.</p> <p>To sign up for EFT or to manage account changes, go to the following secure electronic EFT registration platform website for Enroll Safe: https://enrollsafe.payeehub.org/</p> <ul style="list-style-type: none"> • For questions, please contact 877-882-0384 or email Support@payeehub.org
<p>Grievances</p>	<p>Grievance is an expression of dissatisfaction about any matter or aspect of the health plan or its operations (excluding payment disputes or adverse medical actions). Provider grievances should be submitted to: Anthem Blue Cross and Blue Shield Healthcare Solutions 9133 W. Russell Road Las Vegas, NV 89148</p>
<p>Medicaid ID</p>	<p>Anthem requires providers to hold a valid Nevada Medicaid ID.</p> <p>If providers are not effective with Nevada Medicaid, they may not join Anthem until they become effective.</p> <p>Providers must comply with Nevada Medicaid revalidation efforts. If a provider does not revalidate within 120 days, providers will be terminated from Anthem’s network.</p>
<p>Medical Necessity Appeal Information</p>	<ul style="list-style-type: none"> • Medical necessity appeals must be filed within 60 calendar days from the date on the notice of action/denial. • You may pursue an appeal on behalf of the member with the member’s written permission. • We will send a determination letter within 30 calendar days of receiving the appeal request. • Medical necessity appeals are eligible for one level of appeal. • Submit a medical necessity appeal to: Anthem Blue Cross and Blue Shield Healthcare Solutions Medical Appeals P.O. Box 62429 Virginia Beach, VA 23466-2429 • Medical necessity appeals can be submitted through the Availity website: https://www.availity.com.

Member Eligibility	<p>Member eligibility must be verified at each visit prior to services being rendered</p> <p>To verify member eligibility, log on to Availity at availity.com. From Availity’s homepage, select Patient Registration > Eligibility & Benefits.</p> <p>You may also call Provider Services and use our Automated member eligibility line: 844-396-2330</p>
National Provider Identifier	<p>National Provider Identifier (NPI) — The Health Insurance Portability and Accountability Act (<i>HIPAA</i>) of 1996 requires the adoption of a standard unique provider identifier for healthcare providers.</p> <p>All participating providers must have an NPI number.</p> <p>An NPI is a 10-digit, intelligence-free numeric identifier. Intelligence-free means the numbers do not carry information about healthcare providers, such as the states in which they practice or their specialties.</p> <p>You can apply for an NPI by:</p> <ul style="list-style-type: none"> • Completing the application online at https://nppes.cms.hhs.gov; estimated time to complete the NPI application is 20 minutes. • Completing a paper copy by downloading it at https://nppes.cms.hhs.gov. • Calling 800-465-3203 and requesting an application.
Notification/ Precertification	<p>Should be submitted via the following methods:</p> <ul style="list-style-type: none"> ○ Availity (https://www.availity.com) ○ Website: https://providers.anthem.com/nv ○ Telephone: 844-396-2330 ○ Medical fax: 800-964-3627 ○ Pharmacy phone: 844-396-2330 ○ Pharmacy fax: 866-920-8362 <ul style="list-style-type: none"> • Data required for complete notification/precertification: <ul style="list-style-type: none"> ○ Member ID number ○ Legible name of referring provider (provider’s name) ○ Legible name of individual referred to provider (member’s name) ○ Number of visits/services ○ Date(s) of service ○ Diagnosis ○ CPT code • In addition, clinical information is required for precertification. <p>Referral and certification forms are located at https://providers.anthem.com/nv.</p>
Provider Services Representatives	<p>For more information, contact Provider Services at 844-396-2330.</p>

4 PRIMARY CARE PROVIDERS

4.1 Primary Care Providers/Primary Care Sites

Members will be assigned to a PCP or primary care site (PCS) within five business days of the effective date of enrollment. Members can choose either a PCP or a PCS for their primary healthcare. We may auto-assign a PCP or PCS that has traditionally served the Medicaid population to an enrolled member who does not make a selection at the time of enrollment.

The PCP is a network provider responsible for the complete care of their patient, our member. The PCP serves as the entry point into the healthcare system for the member. The PCP is responsible for the complete care of their patient, including but not limited to providing primary care, coordinating, and monitoring referrals to specialist care, authorizing hospital services, and maintaining the continuity of care. PCP responsibilities include at a minimum:

- Managing the medical and healthcare needs of members to ensure all medically necessary services are made available in a timely manner.
- Monitoring and following up on care provided by other medical service providers for diagnosis and treatment to include services available under fee-for-service Medicaid.
- Providing the coordination necessary for the referral of patients to specialists and to services that may be available through fee-for-service Medicaid.
- Maintaining a medical record of all services rendered by the PCP and other referral providers.
- Freely communicating with members about treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

A PCP must be a participating physician or network provider/subcontractor who provides or arranges for the delivery of medical services, including case management, to ensure all services that are found to be medically necessary are made available in a timely manner. The PCP may practice in a solo or group setting or may practice in a clinic (for example, a federally qualified health center [FQHC], rural health center [RHC]) or outpatient clinic).

A PCS is a location, usually a clinic, where a member chooses to access primary healthcare. The member's medical record is maintained at this location, and a rotating staff of physicians manages and coordinates the member's medical needs.

We encourage members to select a PCP/PCS who provides preventive and primary medical care as well as precertification and coordination of all medically necessary specialty services. We encourage our members to make an appointment with their PCPs/PCSs within 90 calendar days of their effective dates of enrollment.

FQHCs and RHCs may function as PCPs/PCSs. Providers must arrange for coverage of services to assigned members 24 hours a day, 7 days a week, in person or by an on-call physician. Providers must have the office telephone answered after hours by an answering service that can contact the PCP/PCS or another designated network medical practitioner or instructs the member that the provider will contact the member back by the next business day. Finally, each PCP/PCS must provide a minimum of 20 office hours per week of personal availability as a PCP/PCS.

4.2 Provider Specialties

Providers with the following specialties can apply for enrollment with us as a PCP/PCS:

- Advanced nurse practitioner
- Family practitioner
- General practitioner
- General pediatrician
- General internist
- Nurse practitioner certified as specialist in family practice or pediatrics
- Obstetrician/gynecologist (OB/GYN)
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) with a specialty in general practice, family practice, internal medicine, pediatrics, obstetrics/gynecology, or nurse midwifery

To be a PCP, you must be enrolled in the Nevada Medicaid program at the service location where you wish to practice as a PCP/PCS before contracting with us.

4.3 PCP/PCS On-site Availability

We are dedicated to ensuring access to care for our members, and this depends upon the accessibility of network providers. Our network providers are required to abide by the following standards:

- The PCP/PCS must offer telephone access for members 24 hours a day, 7 days a week.
- A 24-hour telephone service may be utilized. The office telephone may be answered after hours by an answering service that can contact the PCP/PCS or another designated network medical practitioner or instructs the member that the provider will contact the member back by the next business day.
- The PCP/PCS or another physician/nurse practitioner must be available to provide medically necessary services.
- Covering physicians are required to follow the referral/precertification guidelines.
- It is **not** acceptable to automatically direct the member to the emergency room when the PCP/PCS is not available.
- We encourage our PCPs/PCSs to offer after-hours office care in the evenings and on weekends.

4.4 Provider Disenrollment Process

You may cease participating with us for either mandatory or voluntary reasons.

Mandatory disenrollment occurs in the event you become unavailable due to immediate, unforeseen reasons. Examples of this include death and loss of license. Members are auto assigned to another PCP/PCS to ensure continuous access to our covered services as appropriate. We will notify members of any termination for PCPs/PCSs or other providers from whom they receive ongoing care.

We will also notify affected members if you disenroll for voluntary reasons such as retirement. You must give written notice to us within the time frames specified in your *Participating Provider Agreement* with us. Members linked to a PCP/PCS who have disenrolled for voluntary reasons will be notified to self-select a new PCP/PCS.

Members' medical information must be sent to the new PCP/PCS in order to provide continuity of care, regardless of whether you had mandatory or voluntary reasons for disenrollment.

4.5 Assigned Member Panel

As a PCP/PCS, you are able to receive a monthly listing of your panel of assigned members. If a member calls to change their PCP/PCS, the change will be effective the next business day. You should verify each Anthem member receiving treatment in your office is on our membership listing. You can pull your member panel on our provider website by logging into Availity and going to *Payer Spaces > Provider Online Reporting (POR) > Member Panel Listing/Member Reports*. Contact a Provider Relationship Account Consultant if you have questions. For questions regarding a member's eligibility, visit our website at <https://providers.anthem.com/nv> or call our automated Provider Inquiry Line at **844-396-2330**.

5 MEMBER ENROLLMENT

5.1 Member Eligibility

Eligibility of Medicaid members is determined by the Division of Welfare and Supportive Services (DWSS). DWSS notifies the state's fiscal agent, who enrolls members.

Medicaid and Nevada Check Up members who meet the state's eligibility requirements for participation in managed care are eligible to join our healthcare plan.

Members are enrolled for a period of 12 months contingent upon continued Medicaid or Nevada Check Up eligibility.

We do not, on the basis of health status or need for health services, discriminate against members eligible to enroll. We will not deny the enrollment of or discriminate against any Medicaid or Nevada Check Up member eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discrimination on the basis of race, color, or national origin. If the member was previously disenrolled from Anthem as the result of a grievance we filed, the member will not be re-enrolled with us unless the member wins an appeal of the disenrollment.

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

regardless of sex, sexual orientation, gender, gender identity, race, color, age, religion, national origin, physical or mental disability, or type of illness or condition.

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

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

- Through the OCR complaint portal at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
- By mail to: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201
- By phone at: **800-368-1019** (TTY/TTD: **800-537-7697**)

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

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

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

- Mail: 9133 W. Russell Road, Las Vegas, NV 89148
- Phone: **888-235-9334**

Equal Program Access on the Basis of Gender

Anthem provides individuals with equal access to health programs and activities without discriminating on the basis of gender. Anthem must also treat individuals in a manner consistent with their gender identity and is prohibited from discriminating against any individual or entity on the basis of a relationship with, or association with, a member of a protected class (that is, race, color, national origin, sex, sexual orientation, gender, gender identity, age, or disability).

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

5.2 Medicaid Enrollment of Pregnant Women

Letters are sent to new Medicaid members requiring them to select a managed care organization (MCO) or have an MCO automatically assigned. We are responsible for all covered medically necessary obstetrical services and pregnancy-related care commencing at the time of enrollment.

5.3 Medicaid Newborn Enrollment

We are responsible for all covered medically necessary services to the qualified newborn. All eligible newborns born to our members are enrolled effective the date of birth if the mother of the newborn was enrolled with us as of the newborn's date of birth. The newborn will remain enrolled with us for as long as Medicaid eligibility is maintained.

5.4 Nevada Check Up Newborn Enrollment

The head of household/mother must notify Division of Health Care Financing and Policy (DHCFP) of the newborn within 14 days of delivery in order to qualify to receive coverage from the date of birth. If the notification is not received in time, the newborn will be enrolled on the first day of the next administrative month from the date of notification. If the mother has other health insurance that provides 30 days of coverage to the newborn, the newborn will be enrolled as of the first day of the next administrative month. If the coverage extends beyond that 30-day period, the child will not be eligible for Nevada Check Up enrollment until after the insurance expires and the child's eligibility is determined under Nevada Check Up eligibility rules.

5.5 Member Identification Cards


Within five business days of notification of enrollment into Anthem, each of our members will be mailed an identification card, which identifies the member as a participant in our program. To ensure immediate access to services, visit our website to verify eligibility. The State will not issue a State Medicaid ID card for those members enrolled in managed care. The holder of the member identification card we issue is a member or guardian of the member. The identification card will include:

- The member's identification number.
- The member's name.
- The member's date of birth.
- The member's enrollment effective date.
- Toll-free phone numbers for information and/or authorizations.
- Toll-free 24/7 NurseLine — available 24 hours a day, 7 days a week.
- Descriptions of procedures to be followed for emergency or special services.
- Our address and telephone number.
- PCP/PCS name and telephone number.


Our members also have access to:

- Print-on-demand ID cards — by logging in to our website, members can download and print their ID cards from home.
- Mobile ID card smartphone app — via our Sydney Health app, available for both iOS and Android users, members can download an image of their current ID cards and fax or email you a copy.

Our member identification card sample:

		Medicaid
Member ID	Primary Care Provider (PCP):	
Program ID #:		
Effective Date:		
Date of Birth:		

Front of card

		Member Services: 1-XXX-XXX-XXXX Provider Services: 1-XXX-XXX-XXXX TTY: 711 24/7 NurseLine/Care On Call: 1-XXX-XXX-XXXX Behavioral Health: 1-XXX-XXX-XXXX Behavioral Health Crisis Line: 1-XXX-XXX-XXXX Authorization: 1-XXX-XXX-XXXX EyeQuest* 1-XXX-XXX-XXXX EyeQuest TTY* 1-XXX-XXX-XXXX
<p>Members: Please carry this card at all times. Show this card before you get medical care. You do not need to show this card before you get emergency care. Possession or use of this card does not guarantee payment.</p>		
<p>Providers: Certain services must be preauthorized. For preapproval/billing information, call 1-844-366-2330. Please submit claims to your local BCBS plan. To ensure proper claims processing, please include the three-digit prefix that precedes the patient's identification number listed on the front of this card.</p> <p>Pharmacies: Submit claims using Express Scripts RXBIN: 003858; RXPCN: MA; RXGRP: WKKA. For technical help, call Express Scripts at 1-844-367-6110.</p>		<p>*Contracts directly with group</p> <p>Claims Filing Address: Anthem Blue Cross and Blue Shield P.O. Box 61599 Virginia Beach, VA 23466-1599</p> <p><small>Anthem Blue Cross and Blue Shield Healthcare Solutions is the trade name of Community Care Health Plan of Nevada, Inc., an independent licensee of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.</small></p>
<small>NV01 02/18</small>		

Back of card

6 ANTHEM HEALTHCARE BENEFITS

6.1 Anthem Covered Services

The following list shows the healthcare services and benefits we cover for Medicaid and Nevada Check Up members. The services covered will be administered up to the limits/guidance as outlined in the appropriate Nevada Medicaid service manuals.

Under the rules of the Nevada Medicaid Services Manual, some services are limited by number of provider visits or by number of supply and equipment items. We have a process to review requests for extra visits or extra supplies. We also have a process to review requests for noncovered services when they are medically necessary.

Some of the services listed below may need preapproval; Please contact us or visit our website at <https://providers.anthem.com/nv> for more information.

Covered Services	Inclusions, Limitations or Exclusions
Applied Behavioral Analysis (ABA)	ABA is a behavior intervention model to treat children with autism spectrum disorder (ASD) as well as children with other developmental diagnoses as clinically appropriate. ABA is rendered to Medicaid-eligible individuals under age 21 in accordance with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. ABA services include <ul style="list-style-type: none"> • Assessment • Evaluation/re-evaluation • Treatment intervention plan with measurable objective goals • Data-driven, targeted goals • Functional communication training • Self-monitoring skills • Adaptive living skills • Cognitive skills • Speech, occupational and physical therapy • Durable medical equipment (DME) • Speech generating device (SGD) • Verbal skills • Language skills • Peer play • Social skills • Prevocational and vocational skills • Parent training • Family education • Family counseling • Case management
Abortions	Excluded except where the pregnant Member suffers from a physical disorder, physical injury, or physical illness, in which the pregnancy itself will endanger the life of the Member unless an

Covered Services	Inclusions, Limitations or Exclusions
	<p>abortion is performed; for sexual assault (rape) or incest; and for treatment of incomplete, missed, or septic abortions.</p> <p>To save the life of the mother, a <i>Certification Statement for Abortion to Save the Life of the Mother</i> must be included.</p> <p>In the case of rape and/or incest, a <i>Certification Statement for Abortion due to Sexual Assault (Rape) or Incest</i> must be included.</p>
Allergy Services	<p>Standard allergy testing and treatment are covered benefits. We do not cover allergy testing that is investigational in nature and not proven to be effective. Examples of allergy tests not covered include but are not limited to the following:</p> <ul style="list-style-type: none"> • Advanced Cell Test (ACT) by ELISA methodology • Applied kinesiology test • Bronchial challenge test • Candida hypersensitivity test • Chemical analysis of body tissues • Chlorinated pesticides (serum) • Conjunctival or nasal challenge test • Cytokine or cytokine receptor assays for multiple chemical sensitivities (MCS) • Cytotoxic food testing (Bryan's test, leukocytotoxic test, ACT) • Electrodermal acupuncture • Environmental challenge testing • Food challenge testing/food immune complex assays (FICA) • Leukocyte histamine release test or lymphocyte proliferation test • Lymphocytes (B or T subsets); may be appropriate for collagen vascular disease, immune deficiency syndromes, leukemia, lymphomas • Mediator release test (MRT) • Multiple chemical or environmental sensitivity testing • Neutralization testing • Prausnitz-Kustner (P-K) testing – passive cutaneous transfer test • Provocation-neutralization testing (Rinkel test), either subcutaneously or sublingually • Pulse test (pulse response test, reaginic pulse test) • Rebeck skin window test • Specific IgG subclass IV testing • Spinal manipulation • Sublingual provocative testing • Urine auto injection • Venom blocking antibodies
Ambulatory Surgery Centers	These services are covered.
Anesthesia	These services are covered.
Assistant Surgeon	These services are covered for qualifying procedures.

Covered Services	Inclusions, Limitations or Exclusions
Assistive/Augmentative Communication Devices	These services are covered.
Audiology Services	<ul style="list-style-type: none"> • Medically needed audiology services including audiology testing, hearing aids and supplies are covered. Certain restrictions apply.
Behavioral Health Services	<p>We cover the following services up to the service limit/guidance in the appropriate Nevada Medicaid services manual:</p> <ul style="list-style-type: none"> • Inpatient mental health and substance abuse services • Outpatient mental health and substance abuse services • Mental health rehabilitative treatment services • Residential treatment center (RTC) for members under 21 years of age
Behavioral Health — Crisis Intervention	These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual.
Behavioral Health — Crisis Stabilization	These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual.
Behavioral Health — Electroconvulsive Therapy (ECT)	These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual.
Behavioral Health — Home Health Care Services	These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual.
Behavioral Health — Hospital Based Detoxification Services/Chemical Dependency Services	We cover admission to substance abuse units of general hospitals or freestanding psychiatric and substance abuse hospitals.
Behavioral Health — Intensive Outpatient Program (IOP), Psychiatric and Chemical Dependency	These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual.
Behavioral Health — Methadone Maintenance Program	These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual.
Behavioral Health — Neurotherapy (Including Biofeedback)	These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual.
Behavioral Health — Observation	Observation cannot exceed 48 hours up to the service limit guidance in the appropriate Nevada Medicaid services manual.
Behavioral Health — Outpatient/Ambulatory Detoxification Services	These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual.
Behavioral Health — Partial Hospital, Psychiatric and Chemical Dependency	These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual.
Behavioral Health — Psychological and Neuropsychological Testing	<p>Includes:</p> <ul style="list-style-type: none"> • Neuropsychological testing • Neurobehavioral testing • Psychological testing <p>These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual.</p>

Covered Services	Inclusions, Limitations or Exclusions
Behavioral Health — Residential Treatment Center (RTC) — Medicaid Members Under 21 Years of Age	Medicaid / Nevada Check Up Effective January 1, 2022, these services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual.
Biofeedback	Limited to codes 90875 and 90876.
Blood Administration and Other Blood Products	These services are covered.
Botox Injections	Covered services include the following: <ul style="list-style-type: none"> • Treatment for spasticity of limbs as a result of brain or spinal cord injury including cerebral palsy • Treatment for eye conditions to stop twitching Services: <ul style="list-style-type: none"> a. May be covered for other medically necessary treatment. b. Are not covered for cosmetic purposes.
Cardiac Rehabilitation Services	These services are not covered.
Chemotherapy/Radiation	These services are covered.
Chiropractic Services	Covered for when a diagnosis of spinal subluxation is made by the referring doctor or under Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for Medicaid members under 21 years of age.
Circumcisions	Routine circumcisions are covered for males up to one year of age. For males older than one year of age, a prior authorization is required to support medical necessity.
Clinic Services	Federally qualified health centers (FQHCs) provide preventive services or services to treat an illness or chronic disease. Rural health clinics (RHCs) provide preventive services. Members can receive covered services at these facilities from the following providers: <ul style="list-style-type: none"> • Physicians • Nurse practitioners • Physician assistants • Certified nurse-midwives • Visiting nurses • Clinical psychologists • Clinical social workers • Registered dietitians • Nutritional professionals Members can self-refer to a federally qualified provider (in- or out-of-network).
Cochlear Implants	These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual.
Cosmetic/Plastics/Reconstructive Procedures	Services are covered only for prompt repair of an accidental injury or the improvement of a malformed body part in order to improve function. Cosmetic surgery directed at improving appearance is not covered.

Covered Services	Inclusions, Limitations or Exclusions
Dental — Oral/Maxillofacial Surgical	<p>Medicaid Members Aged 21 and Older Adult Medicaid members receive emergency extractions and palliative care under certain guidelines and limitations.</p> <p>Medicaid Members under Age 21 and Nevada Check Up Members under Age 19 Surgery to correct a wide range of diseases, injuries and defects to the head, neck, face, jaws, and hard and soft tissues of the lower jaw and face region is covered.</p>
Dental — Preventive/Restorative Refer to FFS NV Medicaid	<p>Effective July 1, 2017, Anthem no longer covers the dental benefit for members. This benefit is delivered directly through the State Medicaid FFS program.</p> <p>Call Liberty Dental at 866-609-0418 or visit LibertyDental.com/nvmedicaid for information about receiving dental services.</p>
Dermatology	<p>These services are covered.</p>
Diabetic Services — Self-Management Training	<p>These services are covered.</p>
Diabetic Services — Supplies	<p>These services are covered.</p>
Diagnostic Testing (Laboratory and Radiology)	<p>These services are covered.</p>
Diagnostic Testing — Nuclear Medicine	<p>These services are covered.</p>
Dialysis Services	<p>These services are covered.</p>
Doula Services	<p>These services are covered under the outpatient encounter with the following limitations:</p> <ul style="list-style-type: none"> • Four visits during the prenatal/antepartum and /or postpartum period (up to 90 days postpartum) <p>These services are covered under the outpatient encounter with the following limitations:</p> <ul style="list-style-type: none"> • Four visits during the prenatal/antepartum and /or postpartum period (up to 90 days postpartum) • One visit at the time of labor and delivery. <p>Non covered services include: Travel time, mileage and services rendered requiring medical or clinical licensure.</p>
Durable Medical Equipment (DME)	<p>These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual.</p> <p>Durable medical equipment is equipment:</p> <ul style="list-style-type: none"> • Used to serve a medical purpose • Fitted for use in the home • Able to withstand repeated use <p>The following DME and medical supplies are examples of services not covered:</p>

Covered Services	Inclusions, Limitations or Exclusions
	<ul style="list-style-type: none"> • Physical fitness or personal recreation equipment • Personal care or hygiene products • Household items, such as air conditioners or ceiling fans • Environmental products • Telecommunications devices for the deaf
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	<p>EPSDT services are covered services for Medicaid Members under age 21. If the member is a Nevada check-up, they do not qualify for EPSDT but they do qualify for Well Baby- Well Child Checks.</p> <p>Complete medical screens include the following:</p> <ul style="list-style-type: none"> • Comprehensive health and developmental history, including an assessment of both physical and mental health development • Comprehensive physical exam • Appropriate immunizations, according to age and health history, unless medically contraindicated at the time • Laboratory tests, including an appropriate blood-lead level assessment • Health education • Vision screening • Hearing screening • Dental screening • Vision, hearing, and dental exams may be performed at other intervals • Other necessary healthcare or diagnostic screens or examinations <p>A member under the age of 21 whose eligibility status is pregnancy related is not eligible.</p> <p>The state Medicaid plan requires that EPSDT screenings are billed using appropriate coding, 99381-99385 or 99391-99395, with modifier EP or TS:</p> <ul style="list-style-type: none"> • Use Modifier EP for routine screening. • Use Modifier TS if referral or follow-up indicated. Also, complete field 21 on the <i>CMS-1500</i> claim form with the ICD-10 code for the condition requiring follow up.
Early Childhood Intervention (ECI) Services	<p>These services are covered.</p>
Educational Consults/Health Promotion	<p>Coverage includes educational consultations for diabetes self-management.</p> <p>Also includes publications, presentations, classroom instruction and preventive services. This is not a separately billable service.</p>
Emergency Services	<p>These services are covered.</p>
Emergency Transportation	<p>These services are covered.</p>
Enteral Nutrition	<p>These services are covered. Certain restrictions apply.</p>

Covered Services	Inclusions, Limitations or Exclusions
<p>Family Planning Services and Supplies</p>	<p>Family planning services include counseling, information, education and communication activities, and delivery of contraceptives/birth control. Family planning services are covered without precertification at any qualified family planning provider, regardless of whether or not the provider is participating in our network.</p> <p>Members can self-refer to a qualified provider (in or out of network).</p> <p>The following services are not covered:</p> <ul style="list-style-type: none"> • Tubal ligations and vasectomies are not covered for: <ul style="list-style-type: none"> ○ Members under 21 years of age. ○ Members adjudged to be mentally incompetent. ○ Members who are institutionalized. • Sterilization reversals are not covered. • Abortions and/or hysterectomies are excluded from family planning. <p>Sterilization and hysterectomy forms are to be completed by the physician and submitted with claim form for payment. Sterilization forms are not required for anesthesiology providers only. Hysterectomy consent forms are required for all provider types.</p>
<p>Gastroenterology Services</p>	<p>These services are covered.</p>
<p>Gender Reassignment Services</p>	<p>These services are covered up to the service limit guidelines in the appropriate Nevada Medicaid services manual for individuals who meet the medical necessity criteria listed in the Nevada Medicaid Services Manual (Chapter 600, Section 608)</p> <p>Please make sure to review <i>Section 607</i> of the <i>Nevada Medicaid Services Manual</i>, as well as the <i>Nevada Billing Guidelines</i>, which includes specific language regarding coverage and limitations. The <i>Nevada Billing Guidelines</i> also offers providers additional guidelines and a list of surgical codes for gender reassignment services that may be billed in conjunction with the KX modifier (CMS1500 claim form) or Condition Code 45 (UB04 claim form).</p>

Covered Services	Inclusions, Limitations or Exclusions
Genetic Testing and DNA Testing	<p>These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual. Genetic and DNA testing is considered medically necessary to establish a diagnosis of inherited diseases when certain conditions are met.</p> <p>Certain restrictions apply. For example, we do not reimburse:</p> <ul style="list-style-type: none"> • Prenatal diagnosis for sex determination of the fetus without implications for genetic disease. • Self-testing home kits. • Genetic testing for cleft disorders. • Blood-typing for paternity testing. • Experimental or investigational genetic testing, including but not limited to: <ul style="list-style-type: none"> ○ Hair analysis. ○ Preimplantation genetic diagnosis. ○ Tumor marker screenings.
Habilitative Services	<p>Services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in a home and community-based setting. The repetitive services required to maintain function generally do not involve complex and sophisticated therapy procedures, and consequently the judgment and skill of a qualified therapist are not required for safety and effectiveness. As such, “maintenance” programs do not meet the requirement of being restorative or rehabilitative and are not a covered benefit by Nevada Medicaid. In certain instances, the specialized knowledge and judgment of a qualified therapist may be required to establish a maintenance program.</p> <p>Habilitation services are provided through Nevada’s FFS delivery system.</p>
Home Health — Rehabilitation (Occupational Therapy [OT], Physical Therapy [PT], Speech Therapy [ST]) and Respiratory Therapy [RT]	<p>Home health agency visits are covered. Certain restrictions apply for services other than skilled nursing. See Nevada Medicaid Services Manual, chapter 1700 for service limitations.</p>
Home Health Skilled Nursing Care	<p>These services are covered.</p>
Home Infusion/Total Parenteral Nutrition	<p>These services are covered.</p>
Hyperbaric Oxygen Therapy	<p>Topical hyperbaric oxygen therapy is not covered.</p>
Hysterectomies	<p>Hysterectomies are not covered for the sole purpose of sterilization.</p> <p>Whenever a hysterectomy is performed, abortion/sterilization/hysterectomy (ASH) forms must be completed by the physician and submitted with claim form for payment. Please complete the <i>Sterilization Consent Form</i> at https://www.medicaid.nv.gov/Downloads/provider/FA-56.pdf.</p>

Covered Services	Inclusions, Limitations or Exclusions
	Sterilization forms are not required for anesthesiology providers only. Hysterectomy consent forms are required for all provider types.
Immunizations	See section 6.7
Inpatient Medical and Surgical	These services are covered.
Medical Supplies	These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual.
Medical Nutrition Therapy	<p>Anthem reimburses participating registered dietitians for medical nutrition therapy (MNT) services rendered to eligible Nevada Medicaid members.</p> <p>To receive nutrition/dietician related services members must have written orders of a physician, physician's assistant (PA) or advanced practice registered nurse (APRN). The treatment must also be designed and approved by a registered dietitian. Certain limitations apply.</p> <p>Coverage includes:</p> <ul style="list-style-type: none"> • Initial nutrition and lifestyle assessment. • One-on-one or group nutrition counseling. • Follow-up intervention visits to monitor progress in diet management. • Reassessment as necessary to ensure compliance with the dietary plan.
Mammogram Screening	Limited to one per year.
Nebulizers	These services are covered. Certain restrictions apply.
Neurology Services	These services are covered.
Obesity Surgery/Bariatrics	These services are covered for people who meet the medical necessity requirements listed in the Nevada Medicaid Services Manual (Chapter 600, Attachment A, Section 6-07)
Observation — Medical	<p>Observation services are provided by the hospital and supervising physician to member held but not admitted into an acute hospital bed for observation.</p> <p>Consistent with federal Medicare regulations, the HCFP reimburses hospital observation status for a period up to but no more than 48 hours.</p> <p>**Notification is NOT required unless the member converts/admits as inpatient.</p>
Obstetrical Care	<p>Obstetrical ultrasound of a pregnant uterus is a covered benefit when it is determined to be medically necessary, up to the service limit guidance in the appropriate Nevada Medicaid services manual.</p> <p>Please refer to the Nevada Medicaid Billing Manual for information regarding delivery claims</p>

Covered Services	Inclusions, Limitations or Exclusions
	<p>When possible, a pregnant woman can remain in the care of a non-network provider.</p> <p>Professional delivery claims with dates of service January 1, 2018, or after with gestational ages of 37 and 38 weeks will require a supporting medically necessary diagnosis code for the early delivery. If a professional delivery claim is submitted without evidence of medical necessity, we will deny the claim with the explanation code k34 — <i>Delivery is not medically indicated</i>. You may resubmit the claim with the appropriate supporting diagnosis code or submit an appeal with the relevant medical records.</p>
Office Visits	These services are covered.
Spinal Manipulation	Osteopathic manipulation services are limited to codes 98925 through 98929. These services are covered per the Nevada Medicaid service manual.
Otolaryngology (ENT)	These services are covered.
Out-of-Area Care	<p>Out-of-area or out-of-state emergency care does not require a prior authorization. Generally, post-stabilization procedures do require prior approval. However, if post-stabilization services are administered to maintain the member’s stabilized condition within one hour of the request for authorization, such services will still be covered. Also, if post-stabilization care — administered to maintain, improve, or resolve the member’s stabilized condition — requires prior approval and we do not respond within one hour, we will pay the provider for that stabilization care. We will not pay the provider an amount any greater than we would pay a network provider for those services.</p> <p>Nonemergency, care requires prior authorization. If our network is unable to provide medically needed services in the member service area (or state), we will cover these services adequately and in a timely manner for as long as the services are not available in our network.</p> <p>Native Americans may access and receive medically necessary services at an Indian Health Service (IHS) facility or tribal clinic.</p>
Pain Management	These services are covered. Medical necessity review may be required for prior authorization.
Perinatology (Maternal/Fetal Care)	These services are covered.
Personal Care Services including Assistants	<p>These services are covered under certain circumstances as outlined in the Medicaid Service Manual (MSM), including but not limited to:</p> <ul style="list-style-type: none"> • Assistance with bathing, grooming, and dressing (one service). • Assistance with toileting needs.

Covered Services	Inclusions, Limitations or Exclusions
	<ul style="list-style-type: none"> • Assistance with transferring and positioning non-ambulatory members. • Assistance with ambulation. • Assistance with eating. • Assistance with medications. <p>Prior authorization is required and completion of FASP (Functional Assessment Service Plan) per MSM.</p> <p>The following services are not covered:</p> <ul style="list-style-type: none"> • Tasks that can be performed by member • Services provided by willing caregiver • Tasks not on approved service plan • Services to maintain household, such as cleaning areas not used by member • Services provided to someone other than member • Care required to be performed by healthcare professional licensed by state
<p>Pharmacy Services</p>	<p>Pharmacy coverage includes:</p> <ul style="list-style-type: none"> • Prescription drugs approved by the United States Food and Drug Administration (FDA) • Over-the-counter (OTC) items approved by the FDA and covered by Fee-For-Service (FFS) program (prescription required) • Self-injectable drugs (including insulin) • Smoking cessation drugs • Various supplies (diabetic testing supplies, spacers) • Vaccines: limited to adults only for flu, shingles, and pneumococcal <p>We do not cover the following:</p> <ul style="list-style-type: none"> • Drugs not approved by the FDA • Drugs from manufacturers that do not participate in a rebate agreement with the Centers for Medicare and Medicaid Services (CMS) • Drugs not on the FFS OTC Drug Formulary • Drugs to help members get pregnant • Drugs used for cosmetic reasons • Drugs for hair growth • Drugs used to treat erectile problems • Drugs used for weight loss • Experimental or investigational drugs <p>Coverage for most drugs is limited to a 30-day supply unless the drug is considered maintenance pharmaceutical for a chronic condition. See Section 5.8 — Pharmacy Services for more information.</p>
<p>Physician Services</p>	<p>All symptomatic and general preventive health visits to physicians or physician extenders within the scope of their licenses are</p>

Covered Services	Inclusions, Limitations or Exclusions
	covered benefits. Physician services covered include services received while admitted in the hospital, outpatient hospital department, in a clinic setting or in a physician's office.
Podiatric Services	<p>Please make sure to consult the <i>Medicaid Services Manual</i> section 603. 8 to review additional limitations including covered and noncovered services.</p> <p>We do not cover preventive care including the cleaning and soaking of feet, application of creams to ensure skin tone, and routine foot care such as trimming of nails and cutting or removal of corns or calluses in the absence of infection or inflammation.</p>
Preventive Health Services	<p>We cover the following preventive health services for Medicaid members:</p> <p>Wellness Visit:</p> <ul style="list-style-type: none"> • Every year for members ages 21 to 39 • Every year for members aged 40 and over <p>Pap Smear and Pelvic Exam:</p> <ul style="list-style-type: none"> • Every year for women aged 21 and over. • Cervical cancer screening is considered medically necessary for women under 21 years of age who are chronically immunosuppressed (for example, organ transplant recipients or seropositive for human immunodeficiency virus). Cervical cancer screening for women less than 21 years of age is considered not medically necessary for all other indications not listed above. <p>Clinical Breast Exam:</p> <ul style="list-style-type: none"> • Every three years for women aged 20 to 39 • Every year for women aged 40 and over <p>Mammograms (Breast X-ray):</p> <ul style="list-style-type: none"> • Every year for women aged 40 and over • Mammography is also available for women between the ages of 35 to 39 who are considered to be at high risk for breast cancer <p>Fecal Blood Occult Test:</p> <ul style="list-style-type: none"> • Every year for members aged 50 and over <p>Sigmoidoscopy and DRE/PSA or Colonoscopy and DRE/PSA:</p> <ul style="list-style-type: none"> • Every 48 months for members aged 45 and over <p>For children's preventive services, see information for EPSDT and well-baby and well-child care.</p>

Covered Services	Inclusions, Limitations or Exclusions
Private Duty Nursing Services	These services are covered under certain circumstances as outlined in the Medicaid service manuals. Private duty nursing services may be approved for chronically ill members who require extensive skilled nursing care to remain at home. Prior authorization is required.
Qualified Clinical Trials	Anthem aligns with the Medicaid State Plan and Social Security Act Amendments and covers the routine costs for items and services furnished in connection with participation in Qualified Clinical Trials. Services must be a Nevada Medicaid covered service. Limitations exist and requests for coverage are subject to Anthems prior authorization and reimbursement policies and procedures. The Qualified Clinical Trial (QCT) principal investigator and the recipient's healthcare provider must complete a Medicaid Attestation Form (FA-110) on the appropriateness of the QCT when submitting a prior authorization.
Rehabilitative Services — Short Term (PT, OT, ST)	This is covered. See Habilitative Services for information.
Respiratory Therapy (RT)	This is covered. All-inclusive Respiratory/Pulmonary Rehabilitation Program is not a Medicaid-covered benefit.
Routine Physicals	These services are covered.
School Health Services (SHS)	<p>SHS services are medically necessary services listed in the student's Plan of Care (POC) and /or preventative services that are coverable under Early Periodic Screening Diagnostic and Treatment (EPSDT).</p> <p>The following services are not covered:</p> <ul style="list-style-type: none"> • Services provided to students aged 21 years or older or under the age of 3 • Services classified as vocational, educational, or recreational • Services to non-Medicaid eligible individuals • Information furnished by a provider to member over the telephone • Any immunizations or biological products and other products available free of charge from the state health division • Transportation of school-aged children to and from school, including specialized transportation for Medicaid-eligible children on days when they receive Medicaid covered services at school
Second Opinions	These services are covered.
Sexual Abuse Exam	These services are covered.
Skilled Nursing Facility (SNF) Services	Covered services include all nursing facilities, swing-bed admissions, and all other medically necessary services through the first 180 days of admission. On the 181st day, these services are covered by FFS.
Smoking Cessation Programs/Supplies	Anthem is working with the EX Program by Truth Initiative®, a digital program for tobacco cessation built in collaboration with the Mayo Clinic.

Covered Services	Inclusions, Limitations or Exclusions
	<p>1. The Ex Program — for adults 18+. A web based comprehensive cessation program — members receive a full year access to 5 components:</p> <ul style="list-style-type: none"> • Self- paced educational materials and resources to help establish a quit date, effective habits, etc. • Text- messaging tailored to the profile established by the user. So, if they are pregnant, it would be relevant to pregnant women: if they are a male who chews, specific to that – etc. • Access to the online community forum-24/7 opportunity to chat with other smokers/quitters, build relationships and get peer support from other people trying to quit or who have been successful at it. • Chat Support – synchronous chat with a certified tobacco cessation specialist. Can be ad hoc or scheduled up to 6 weeks in advance. • NRT meds — 8-week supply of gum, lozenges, or patches — no prescription required - order via text and shipped to their home. <p>2. This is a Quitting program – for teens age 13-17. It is a text-based program to help young people quit vaping. Our teen members that opt-in to the program using an Anthem specific keyword will receive guidance on the dangers of vaping and tobacco use, help establishing a quit date and a plan, and begin receiving daily text messages tailored for their age and product use to keep them on track. They can also access on – demand content for stressful situations, social support or relapses using other special keywords provided to them through the program. The program incorporates messages from other young people about their own quit journey, and shares relatable, evidenced based facts on the health aspects of this behavior all in private, digital format.</p> <p>Providers play an influential role in helping patients overcome tobacco addiction - and we can help you make an even bigger impact. Tell your patients who are Anthem Blue Cross and Blue Shield Health Care Solutions (Anthem) members that they have access to a tobacco cessation program.</p> <p>Members have access to the EX Program through any browser on their smartphone, tablet, or PC. Members can self-register at: Go.TheEXProgram.com/AnthemNV</p> <p>Our Condition Care (CNDC), Care Management (CM), or OB case management clinicians perform assessments for each member that include health risk due to smoking or exposure to smoke.</p>

Covered Services	Inclusions, Limitations or Exclusions
	<p>Care managers educate the member at risk on the effects of smoking and engages in a discussion around smoking cessation strategies and programs. Health Tips, educational tools that address tobacco use, are sent to members who are enrolled in the condition care, CM, or OB case management programs and who have been identified as using tobacco products.</p> <p>Members may also be referred to a behavioral health provider for evaluation and treatment of substance abuse, including tobacco use.</p>
Transplants	<p>These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual. We cover the following transplant services for members who meet the eligibility and medical necessity requirements:</p> <ul style="list-style-type: none"> • Bone marrow/stem cell • Cornea • Kidney • Liver transplantation for children (under 21 years old) with extrahepatic biliary atresia or for children or adults with any other form of end-stage liver disease. Coverage is not provided with a malignancy extending beyond the margins of the liver or those with persistent viremia. • Heart, lung, pancreas, and intestinal transplants (and their associated costs) are NOT covered for adults. <p>Medicaid members under 21 We cover medically necessary transplants.</p>
Vision Ophthalmology/Optomety	<p>Exams Routine comprehensive exams and/or refractive exams of the eyes and glasses with a prescription for and provision of corrective eyeglasses are covered for Medicaid members of all ages once every 12 months. Exceptions require prior authorization. Eye exams for the following medical conditions/situations are covered based on medical necessity, do not require prior authorization, and are not limited to the 12-month restriction for examination and lenses:</p> <ul style="list-style-type: none"> • Glaucoma • Diabetes • Healthy Kids/EPSTD referral services • Following cataract surgery <p>Lenses Covered for members of all ages. No prior authorization is needed for members under age 21. Prior authorization is required for members aged 21 and over if the 12-month limitation is exceeded.</p> <p>Frames Existing frames must be used whenever possible. If new frames are needed, they may be metal or plastic.</p>

Covered Services	Inclusions, Limitations or Exclusions
	<p>Contacts Not covered unless:</p> <ul style="list-style-type: none"> • Medically needed to meet minimum criteria required to avoid legal blindness. • Medically needed following cataract surgery. • Used as a means to avoid heavy glasses, which would hurt the bridge of the nose. • Required when the member has a diagnosis of keratoconus. <p>EPSDT (Healthy Kids) Vision exams are covered as referred by the child's PCP or developmental or educational professional. Exams under this condition do not require a prior authorization.</p> <p>Glasses may be provided at any interval without prior authorization of EPSDT members long as there is a change in refractive status from the most recent exam.</p> <p>The following are not covered:</p> <ul style="list-style-type: none"> • Sunglasses and cosmetic lenses • Replacement lenses unless there is a significant change in refractive status • Transitional lenses • Faceted lenses • Additional cost of extended repair or replacement warranty • Frames with ornamentation • OkFrames, which attach to or act as a holder for hearing aid(s)
Well-Baby and Well-Child Care	Routine well-baby and well-child care services are covered for member ages 0 to 18 and include routine office visits with health assessments and physical exams, routine lab work, and age-appropriate immunizations.

Note: We do **not** cover the use of any experimental procedures or experimental medications, except in the situation of EPSDT where peer reviewed studies demonstrate the treatment to be effective.

6.2 Value-Added Benefits

The following table shows the value-added benefits Anthem covers for Medicaid and Nevada Check Up members.

	Definition and Description	Member Eligibility	Limits or Restrictions	Providers	Member Access
Membership to Boys & Girls Clubs	Free membership for children	Children ages 5 to 14	None	N/A	Members may access a Boys & Girls club directly. A list of participating clubs is available from Member Services.
Sports/School Physicals	One sports/school physical every 12 months	Child ages 6 to 18	Physicals must be conducted by an Anthem PCP/PCS.	Any Anthem PCP/PCS	Members can self-refer to any Anthem PCP/PCS.

Extra Anthem benefits

We provide extra benefits just for our members. These extra benefits are called value-added services and include:

- Free Boys & Girls Club memberships for children ages 5 to 14.
- Free sports physicals every 12 months from a plan PCP for children ages 6 to 18.
- New Baby, New LifeSM education and rewards program for all pregnant members.
- My Advocate[®] program screening and health education program for pregnant members.
- Books for Babies Program Gift card to purchase books online
- 24/7 NurseLine talk to a registered nurse about medical questions and concerns anytime, day or night.
- LiveHealth Online to “visit” a doctor through online video chat anytime, day or night, to find help when you need an appointment fast, or to receive quick care for minor illnesses like colds, allergies, flu, or infections.
- Free cellphone with free monthly minutes, data, and text messages.
- Anthem Healthy Rewards programs: receive debit card dollars for doing things that are good for your health.
- Holistic smoking cessation program: our program includes coaching, written and online education, and nicotine replacement therapy (NRT) delivered to your home.
- Free dental hygiene kits to keep your teeth healthy.
- Improved Member Services department: representatives provide personalized referral assistance and appointment scheduling to help you go to the doctor when you need care.
- Transitional care assistance for extra help moving from a hospital stay to your home.
- GED/HiSet assistance: we will cover the costs of the high school equivalency test.
- Identification support: if you lose your green card, ID or birth certificate, our behavioral health case managers will help you receive a copy of the original document(s), and we will cover the cost of the replacements.

- Find Help® Community Resource Link: an online resource to help you find all available local community-based programs, benefits, and services.
- Shelter bed reservations program: daily shelter beds available along with short-term, long-term and respite housing for those who qualify
- Costco Gold Card membership one per family.
- Online Active and Fit program: provides eligible members with a robust resource library of over 1,000 health-oriented courses, classes, articles, videos, and tip sheets based on up-to-date clinical information. For members ages 17 and up.
- WW® (formerly Weight Watchers®): members can receive one WW voucher good for the initiation fee and 13 weeks of classes. For members ages 17 and up.
- Electric breast pump: for pregnant members six months prior to delivery and new moms up to six months post-delivery who plan to breastfeed. This benefit also covers babies up to 6 months

Flu Pandemic Kit

Many of our members face barriers to preparing for Flu Season. These may include mobility, transportation, or economic factors. We will make Flu Protection Kits available to all of our members.

The kits will contain:

- Masks - 10 ct.
- Sanitizer
- Sani-Hands Wipe, Alcohol, Individually Packed, 8" x 5.3

One Kit per Member. A non-covered parent may request a kit for their child if Anthem covers the child.

One kit per year

Non-Pharmacologic Pain Management

Non-pharmacological pain therapy refers to interventions that do not involve the use of medications to treat pain. Catalogue items can include items such as: handheld massagers, TENS units, Theracane, Epsom salts, massage oils and lotions, lidocaine cream, cold/hot packs, yoga bd mats, etc.

Members can purchase up to <\$100> of therapeutic devices to help them manage their pain.

Eligible members include those who have a clinical diagnosis related to chronic pain. Limit one package per household per lifetime.

Maternal Health – Meal Program

Members who qualify or are identified by a provider can receive up to 2 meals per day for 14 days providing 28 meals per member total. Meals are customized to enhance recuperation for each member. We offer low-sodium and low-fat options, diabetic-friendly, gluten-free, vegetarian, renal-friendly, and pureed meals.

Anthem will provide home-delivered, medically tailored meals to pregnant members who are on bed rest or post-partum members or who were recently discharged. The meals will be home delivered. We are not able to deliver meals to members who are not housed at this time.

Youth Behavioral Health – Calm App

To help youth improve their mental health state, Anthem will give a year subscription to the Calm App. Members can access age-appropriate meditations and sleep aids to help calm the mind and body, aiding to reduce stress and anxiety. This resource gives our youth and adolescent members' tools to practice

leading happier lives. Offered in Spanish, German, French, Portuguese, Japanese and Korean. Eligible members aged 18 and younger may receive a yearly subscription for the Calm App.

Emotional Well Being

Members ages 13+ receive access to our Emotional Well-Being Resource is a web and mobile online community designed to help members cope with emotional health issues such as depression, anxiety, and stress, chronic pain, insomnia, and managing drugs or alcohol.

Baby Essentials Bundle Package

“Eligible Members” - which covers Pregnant moms, new moms, and/or babies up to 12 months - will be able to choose 2 of the following:

- Breastfeeding Pillow
- Convertible Car Seat
- Portable Crib
- Highchair
- Breastfeeding Support Kit
- Safe Sleep Kit
- Diapers
- Microwave Sterilizer
- Microwave steam bags
- Baby Monitor - Video
- Baby proof items - plug protectors, Doorknob covers, Cabinet & Drawer Latches
- Infant/Preemie Car Seat

Fresh Fruits and Vegetables

Farm fresh produce delivered directly to member's doors. Members can select from a wide array of boxes including a Fruit and Veggie Mix, all fruit, all veggie, Diabetic boxes, or Ethnic Cuisine Box. Members will receive one produce box per month for three months. Eligible for Members with a primary or secondary clinical diagnosis of obesity or diabetes/prediabetes. One box for three months per household per year

Grooming Kit for Foster Care Youth

Eligible members can receive a Grooming Pass and Grooming Box to help educate and establish proper self-care skills. The Grooming Pass can be used as a form of payment only at beauty and barber salons. The Grooming box will contain ethnic specific hair grooming products appropriate for youth along with a book on how to care for textured hair.

All youth/young adults in Foster Care up to age 26 are eligible

Maternal Health Transportation Benefit

Anthem will provide a Bus Pass for one month to help them with their transportation needs. Members who do not have access to the bus can opt to choose between a \$50 Uber card or a \$50 gas card. New moms or babies and children up to 5 years old can obtain the benefit. One time per year

Industry Certification

Anthem will cover the cost of covering the exam fees for industry certifications in fields such as early childhood education, foundations of reading, business education, computer science, technology education, English language arts, health, and marketing.

Limited to members who are recent high school graduate (or GED/HiSET recipients), recent vocational/college graduates, and members reentering society from incarceration. One per year

Internet Essentials Package

Members will receive up to a \$300 allowance to help cover the cost of internet services. To help ensure members have access to the internet for educational pursuits or employment opportunities, eligible members can receive up to \$300 towards the cost of internet services. Funds can be used to purchase modems, routers, and any additional equipment that is essential to obtain (or strengthen) an internet connection, as well as to help cover monthly service charges. For members without current internet access, the funds can be used for installation and set-up fees as well. Members must have been previously incarcerated within the 12 months. Eligible for members in re-entry program and are seeking employment or furthering education. One per lifetime

Free Laptop Program

Eligible for members transitioning from incarceration and pursuing education/employment
Members will be able to receive a free laptop to help with employment and educational pursuits.
Members must have been previously incarcerated within the past 12 months. One per lifetime

Virtual Tutorial Services - ULearn - Elevation Strategic Solutions

Members can get help with language arts, math, science, social studies, and foreign language to help increase confidence, achievement, and academic readiness.

Maximum allowance of 24 hours per member per year- ULearn - Elevation Strategic Solutions
Limited to members aged 8-17. Members must be at risk of failing a grade (or individual subject) to be eligible or any Member in the juvenile justice system

Life Transition Kit

To support members transitioning for an institutional setting in to housing or homelessness. We will provide a kit to help the member get settled.

The kits include:

- First aid supplies such as bandages and ointment
- Toothpaste, travel toothbrush, mouthwash, dental floss
- \$15 Subway gift card
- Emergency blanket

College Application Fee Support

Members ages 17+ will receive \$50 to use for application fee of college applications

Gym Membership

Eligible members ages 18+ with a primary or secondary clinical diagnosis of obesity or diabetes/prediabetes will receive up to a \$100 allowance to help cover costs for a gym membership.

We give you these benefits to help keep you and your family healthy and to thank you for choosing Anthem as your health insurance plan.

Patient360

Patient360 is an interactive dashboard that gives you a robust picture of a member's health and treatment history and helps you facilitate care coordination. Patient360 is available through our secure self-service website, which gives you instant access to detailed information about your Anthem patients. By selecting each tab in the dashboard, you can drill down to specific items in a member's medical record. Information is available regarding a member's demographics, care summaries, claims details, authorization details, and pharmacy and care management-related activities.

Patient360 is a multifaceted perspective on member utilization and pharmacy patterns. With this level of detail at your fingertips, you will avoid duplicating services, identify care gaps and trends and coordinate care more effectively. In addition, accessing this data electronically will reduce the number of communications needed between PCPs and case managers, as well as significantly increase patient confidentiality.

To access Patient360:

1. Log in to Availity at [availity.com](https://www.availity.com).
2. Select **Nevada** from the state drop down box.
3. Select **Payer Spaces**.
4. Select the **Anthem Blue Cross and Blue Shield Healthcare Solutions** tile.
5. Select the **Applications** tab.
6. Select **Patient360**.
7. Enter the required fields including the Anthem member ID.

Note: Your organization administrator must assign you the Patient360 role before you are able to access the tool.

6.3 Healthy Rewards Programs for Members

The Healthy Rewards Program is a corporate-supported, standardized Member Incentive Program (MIP) that enables the health plan to reward members for completing specific healthy activities for non-cash rewards that may assist in the prevention, wellness, or management of chronic conditions. The program is highly versatile and intended to boost clinical performance metrics and health outcomes. A few of the incentives are as follows:

- Incentive for child and adolescent well-care visits 15 months to 19 years
- Incentive for vaccinations: HPV, CIS Combo 10
- Incentive for breast cancer screening
- Incentive for diabetes screening: HbA1c
- Incentive for cervical cancer screening
- Incentive for diabetic retinal eye screening
- Incentive for asthma medication fills
- Incentive for high blood pressure medication fill
- Incentive for prenatal and postpartum care visit
- Incentive for well-baby visits
- Incentive for completing quizzes about vaccines, diabetes, and diabetes nutrition

- Incentive for follow-up visits after emergency and inpatient behavioral health visits
- Incentive for Covid vaccine
- Incentive for Influenza vaccine
- Incentive for members on antipsychotics for HbA1c screen
- Incentive for members with diabetes and schizophrenia for diabetes monitoring

6.4 New Baby, New LifeSM Program

New Baby, New LifeSM is a proactive case management program for all expectant members and their newborns. We use several resources to identify pregnancies as early as possible. Sources of identification include, state enrollment files, claims data, hospital census reports, the Availity Maternity form, and notification of pregnancy forms, as well as provider and member self-referrals. Once pregnant members are identified, we act quickly to assess obstetrical risk and ensure appropriate levels of care and case management services to mitigate risk.

Experienced case managers work with members and providers to establish a care plan for our highest risk pregnant members. Case managers collaborate with community agencies to ensure pregnant members have access to necessary services.

When it comes to our pregnant members, we are committed to keeping both parent and baby healthy. That is why we encourage all our pregnant and postpartum members to take part in our New Baby, New Life program, a comprehensive case management and care coordination program which offers:

- Individualized, one-on-one case management support for pregnant members at the highest risk
- Care coordination for those who may need a little extra support
- Digital perinatal educational tools
- Information on community resources
- Incentives to keep up with prenatal and postpartum checkups and well-child visits after the baby is born

As part of the New Baby, New Life program, perinatal members have access to a digital maternity program. The digital program provides pregnant and postpartum members with proactive, culturally appropriate education via a smartphone app. Once members are identified as being pregnant, they will receive an invitation to access this program by downloading the app. After the app is installed and the member registers, they are asked to complete a pregnancy screener. The answers provided in the screener allows Anthem to assess their pregnancy risk.

After risk assessment is complete, the digital program delivers gestational-age-appropriate education directly to the member. This program does not replace the high-touch, individual case management approach for our highest risk pregnant members; however, it does serve as a supplementary tool to extend our health education outreach. The goal of the expanded outreach is to ensure maternity education is available to all perinatal members and help Anthem to identify members who experience a change in risk acuity throughout the perinatal period.

We require notification of pregnancy at the first prenatal visit and notification of delivery following birth. You may choose to complete the notification of pregnancy and delivery in Availity or fax the forms to Anthem at **800-964-3627**.

In addition to submitting the Notification of Pregnancy form, we also encourage providers to complete the Maternity form in Availity Essentials:

- Perform an Eligibility and Benefits (E&B) request on the desired member.
- Choose one of the following benefit service types: maternity, obstetrical, gynecological, or obstetrical/gynecological.
- Before the benefit results screen, you will be asked if the member is pregnant. Choose “Yes”, if applicable. If you indicate “Yes”, provide the estimated due date, if it is known, or leave it blank if the due date is unknown. You may update the estimated due date as soon as it is known.
- After submitting your answer, the E&B will display. If the member was identified as pregnant, a Maternity form will be generated. Once generated, you may access the form in the Maternity work queue.
- After delivery, go into the Maternity Work Queue and update details, complete the questions in the form, and SUBMIT the form for all PENDING status forms.

We encourage healthcare providers to share information about the New Baby, New Life program and the digital maternity tools offered at Anthem with members. Members may access information about the products that are available by visiting the Anthem member website.

For more information about the New Baby, New Life program or the digital maternity tools, reach out to your OB Practice Consultant or Provider Services at **844-396-2330**, or refer to our website at <https://providers.anthem.com/nevada-provider/patient-care/maternal-child-services>.

6.5 NICU Case Management

For parents with infants admitted to the Neonatal Intensive Care Unit (NICU), the health plan offers the NICU Case Management program.

Highly skilled and specialized NICU case managers work closely with the child’s parents to help them cope with the day-to-day stress of having an infant in the NICU, encourage them to stay actively involved in their child’s care, and assist them in preparing themselves and their homes for their child’s upcoming discharge from the NICU.

After the NICU member is safely discharged from the hospital, the NICU case manager continues to provide parents with education and support to effectively guide them to appropriate community resources, foster improved member outcomes, and prevent unnecessary hospital readmissions.

The stress of having an infant in the NICU may result in post-traumatic stress disorder (PTSD) symptoms for parents and loved ones. To reduce the impact of PTSD among our members, we assist by:

- Guiding parent(s) into hospital-based support programs, if available.
- Screening parent(s) for PTSD approximately one month after their baby’s date of birth.
- Referring parent(s) to behavioral health program resources, if indicated.
- Reconnecting with a one-month follow-up call to assess if the parent(s) received benefit from initial contact and PTSD awareness.

Our case managers are here to help you. If you have a patient in your care that would benefit from NICU Case Management program, please call Provider Services at **844-396-2330**.

6.6 Early and Periodic Screening, Diagnosis and Treatment/Well-Child Visits/Healthy Kids

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) are preventive and diagnostic services available to Medicaid members under age 21. In Nevada, the EPSDT program is known as Healthy Kids. The program is designed to identify medical conditions and to provide medically necessary treatment to correct such conditions. Healthy Kids offers the opportunity for optimum health status for children through regular, preventive health services and the early detection and treatment of disease. EPSDT services include but are not limited to the following:

- Screening services, which include a comprehensive health and developmental history (including assessment of both physical and mental health development)
- A comprehensive, unclothed physical exam
- Age-appropriate immunizations (according to current American Committee on Immunization Practices [ACIP] schedule)
- Laboratory tests (including blood lead level assessment appropriate to age and risk as directed by current federal requirements)
- Health education/anticipatory guidance
- Vision screen
- Dental screen
- Hearing screen
- Age-appropriate TB screening per CMS requirements
- Other necessary healthcare, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state Medicaid plan

Healthcare Effectiveness Data and Information Set (HEDIS) quality measurements require that all well-child/adolescent visits for Medicaid and Check Up measures must also include:

- BMI percentile documentation.
- Counseling for nutrition.
- Counseling for physical activity.

The state Medicaid plan requires that EPSDT screenings are billed using appropriate codes, 99381-99385 or 99391-99395, with modifier EP or TS:

- Use modifier EP for service that is part of the Medicaid EPSDT program.
- Use modifier TS if referral or follow-up is indicated. Also, complete field 21 on the *CMS-1500* claim form with the ICD-10 code for the condition requiring follow up.

Anthem allows reimbursement for preventive medicine (that is, well-child) and limited sick visits on the same day unless provider, state, federal or CMS contracts or requirements indicate otherwise.

Reimbursement is based on the fee schedule or contracted/negotiated rate for the preventive medicine and the allowed sick visit under the following conditions:

- Modifier 25 must be billed with the applicable evaluation and management (E&M) code for the allowed sick visit. If modifier 25 is not billed appropriately, the sick visit will be denied.
- Appropriate diagnosis codes must be billed for respective visits.

Note: Nevada Check Up members are not eligible for EPSDT, but they are eligible for well-child care services.

Well-child care services are available for Nevada Check Up members ages 0 to 18. These services include regular or preventive diagnostic and treatment services necessary to ensure the health of babies, children and adolescents as defined by the state.

Well-child care services should be performed for newborns in the hospital and then as follows:

Age Range						
Under 1	1 to 2	3 to 5	6 to 9	10 to 14	15 to 18	19 to 20
3-5 days old	12	3	6	10	15	19
1 month	months	years	6	years	years	years
2 months	15	4	6	11	16	20
4 months	months	years	9	years	years	years
6 months	18	5		12	17	
9 months	months	years		years	years	
	24			13	18	
	months			years	years	
	30			14		
	months			years		

6.7 Immunizations

You must enroll in the Vaccines for Children (VFC) program administered by the Nevada State Division of Public and Behavioral Health (DPBH). If you are licensed by the state to prescribe vaccines, contact the Nevada State DPBH to enroll. The Nevada State Immunization Program will review and approve your enrollment request. As a VFC-enrolled provider, you must cooperate with the Nevada State DPBH for purposes of performing orientation and monitoring activities regarding VFC program requirements.

Upon successful enrollment in the VFC program, you may request state-supplied vaccines to be administered to members through 18 years of age in accordance with the most current Advisory Committee on Immunization Practices (ACIP) schedule and/or recommendation and following VFC program requirements.

Participate in the Nevada State Health Division’s Immunization Registry by reporting to the state all immunizations of children up to 2 years of age. We will assist you if you do not have the capability to meet these requirements upon request.

Coverage excludes any immunizations, biological products, and other products available free of charge from the State Health Division.

Vaccine administrations are separately reimbursable expenses from well-child exams or office visits. When the vaccine administration is the only service performed, Anthem does not allow reimbursement for a minimal office visit (that is, an office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician where the presenting problem[s] are usually minimal and typically five minutes are spent performing or supervising these services).

Members can self-refer to a qualified provider (in- or out-of-network).

We will reimburse local health departments (LHDs) for the administration of vaccines regardless of whether or not the LHD is under contract with us.

Note: We cover the administration fee only for members less than 21 years of age.

6.8 Well-Child Visits Reminder Program

A list of our members who, based on our claims data, may not have received well-child services according to the above schedule is sent to their PCPs/PCSs each quarter. Additionally, we mail information to these members encouraging them to contact the offices of their PCPs/PCSs to set up appointments for needed services.

Please note:

- The specific service(s) needed for each member is listed in the report. Reports are based only on services received during the time the member is enrolled with us.
- Services must be rendered on or after the due date in accordance with federal EPSDT and state Department of Health guidelines. In accordance with these guidelines, services received prior to the specified schedule date do not fulfill EPSDT requirements.
- This list is generated based on our claims data received prior to the date printed on the list. In some instances, the appropriate services may have been provided after the report run date.
- To ensure accuracy in tracking preventive services, please submit a completed claim form for those dates of service to our Claims department at:
Anthem Blue Cross and Blue Shield Healthcare Solutions
P.O. Box 61010
Virginia Beach, VA 23466-1010

6.9 Blood Lead Screening

You are required to furnish a screening program consisting of a screening and a blood test for the presence of lead toxicity in children. During well-child visits for children between the ages of 6 months and 6 years old, the PCP/PCS will screen each child for lead poisoning. Blood tests should be performed at 12 months and 24 months of age to determine lead exposure and toxicity. In addition, children over the age of 24 months up to 72 months should receive blood screening lead tests if there is no past record of a lead screening.

We contract with MEDTOX Laboratories to provide our PCPs with a filter paper lead screening method. The MEDTOX method of blood lead testing is a fast, noninvasive, and easy way to conduct lead testing. Supplies are provided at no charge to your office; once the sample cards are mailed back to MEDTOX, you can expect results delivered within 24 to 48 hours of receipt.

The Nevada Division of Health Care Financing and Policy (DHCFP) has approved the MEDTOX test as an acceptable technique for lead screening. Bill with CPT code 36416 along with the applicable office visit code when submitting a claim for the procedure.

6.10 Pharmacy Services

Our pharmacy benefit provides coverage for medically necessary medications from licensed prescribers enrolled in Nevada Medicaid Program for the purpose of saving lives in emergency situations or during short-term illness, sustaining life in chronic or long-term illness, or limiting the need for hospitalization. Members have access to most national pharmacy chains and many independent retail pharmacies enrolled in Nevada Medicaid Program including CVS, Smith's (Kroger), and Wal-Mart. Walgreens is not part of the pharmacy network.

We contract with CarelonRx, Inc.* to process prescription drug claims using a computerized point-of-sale (POS) system. This system gives participating pharmacies online real-time access to beneficiary eligibility, drug coverage (to include prior authorization requirements), prescription limitations, pricing/payment information and prospective drug utilization review. Pharmacy providers in the Anthem pharmacy network (CVS, Smith's (Kroger) and Wal-Mart) should submit pharmacy benefit claims to CarelonRx for our members. Pharmacies may dispense up to a 30-day supply of medication. If desirable, members may receive a 60-day supply of maintenance medication through our mail order pharmacy. Pharmacies may dispense up to a 12-month supply for FDA approved contraceptives.

If a member is transitioning to us from FFS or another managed care organization (MCO), we offer a transition benefit for continuity of care. The member will receive a transition benefit for a one-time fill during the first 30 days for any covered drug. Members may receive 2 fills during first 60 days for any maintenance drug and 3 fills during first 90 days for any behavioral health drug. After the member has used the transition benefit, providers will need to submit a prior authorization request for possible approval of the member continuing on this drug.

Members do not have a prescription copay.

Covered Drugs

Our pharmacy program uses a *Preferred Drug List (PDL)*. This is a list of the preferred drugs within the most commonly prescribed therapeutic categories. The *PDL* is comprised of drug products reviewed and approved by our Pharmacy and Therapeutics (P&T) Committee. The P&T Committee is comprised of actively practicing network physicians, pharmacists and other healthcare professionals who evaluate safety, efficacy, adverse effects, outcomes and total pharmacoeconomic value for each drug product reviewed. The *PDL* also includes several over-the-counter (OTC) products that are recommended as first-line treatment where medically appropriate. To prescribe medications that do not appear on the *PDL*, please contact Pharmacy Services at **844-396-2330**. Please refer to our *PDL* or complete formulary on our website.

Pharmacy coverage includes:

- Prescription drugs approved by the United States Food and Drug Administration (FDA)
- Over-The-Counter (OTC) items approved by the FDA and covered by the Fee-For-Service (FFS) Program
 - Note: OTC items still require a prescription in order to be covered under the Medicaid plan and for the pharmacy to be able to dispense the medication.
- Self-injectable drugs (including insulin)
 - Note: Claims for physician-administered injectable medications should be submitted to the medical benefit with a CMS 1500 form and include a procedure code and an NDC.

- Contraceptives (Contraceptive devices are covered under the medical benefit and should be billed to Anthem).
- Smoking cessation drugs
- Various supplies (diabetic testing supplies, spacers)
 - **Note:** Claims for Durable Medical Equipment (DME) supplies (such as, nebulizers, insulin pumps, enteral nutrition) submitted to the medical benefit with a CMS 1500 form and include a procedure code and an NDC
- Vaccines: limited to adults only for flu, shingles, and pneumococcal.
- Free pregnancy test kits from in-network CVS and Walmart (select CVS brand or Walmart Equate brand only); limit of three kits per year for female patients

Services **not** covered by the pharmacy benefit include:

- Drugs not approved by the FDA
- Drugs from manufacturers that do not participate in a rebate agreement with the Centers for Medicare and Medicaid Services (CMS)
- Drugs not on the FFS OTC Drug Formulary
- Drugs to help members get pregnant
- Drugs used for cosmetic reasons
- Drugs for hair growth
- Drugs used to treat erectile problems
- Drugs used for weight loss
- Experimental or investigational drugs

Mandatory Generic Drug Policy

Generic substitution for brand-name equivalent drugs is required. Generic drugs must be provided when available. When a generic drug is available, brand-name products will only be approved through written prior authorization, with the exception of certain Narrow Therapeutic Index (NTI) medications. To prescribe a brand name drug when a generic equivalent is available, the prescriber will need to certify the need by:

- Documenting in the member's medical record the need for the brand-name product in place of the generic form
- Submitting written prior authorization
- Certification must be in the prescriber's own handwriting
- Certification must be written directly on the prescription blank with a phrase indicating the need for a specific brand is required (An example would be "Brand Medically necessary.").

Prior Authorization Drugs

We strongly encourage you to write prescriptions for products as listed on our complete formulary or our *PDL*. Medications not listed in the formulary or *PDL* are considered to be nonformulary and are subject to prior authorization. Some medications listed on our formulary or *PDL* may have additional requirements or limitations of coverage. These requirements and limits may include prior authorization, quantity limits, age limits or step therapy. Additionally, if a medication is available as a generic formulation, this will be Anthem's preferred agent unless otherwise noted. If a brand-name medication is requested when a generic exists, a prior authorization request will need to be submitted. If you have any questions about coverage of a certain medication, please contact the Anthem Pharmacy Department at **844-396-2330** (Monday to Friday, 5 a.m. to 6 p.m. Pacific Time; Saturday from 7 a.m. to 11 a.m. Pacific Time).

To request prior authorization (PA), the provider must contact the Anthem Pharmacy Department at **844-396-2330**. Providers may also submit PA via fax or electronically. Prior Authorization fax forms may be found on the Anthem website at <https://providers.anthem.com/nevada-provider/member-eligibility-and-pharmacy/pharmacy-information>. Providers should 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. Per NV SB167 (2023), antipsychotic step therapy may be bypassed by applicable practitioners. Please complete attestation directly on the Prior Authorization form.

For drugs requiring PA, pharmacies may dispense a 72-hour emergency supply for a Medicaid covered drug to allow time for the PA review. Decisions on pharmacy PAs are made within 24 hours.

6.11 Specialty Drug Program

We contract with CarelonRx and other network pharmacies for high-cost, specialty/self-injectable drugs available under our pharmacy benefit that treat a number of chronic or rare conditions. (Note: CarelonRx should not be used for physician-administered injectable medications. Claims for physician-administered injectable medications covered should be submitted to the medical benefit with a CMS 1500 form and include a procedure code and an NDC.)

Please call CarelonRx at **833-262-1726** to request a specific medication.

A full listing of the medications supplied by CarelonRx can be found on our website at <https://providers.anthem.com/nv> and is current at the time of printing. Because new specialty drugs continually become available, you should check with us before providing any specialty/injectable drugs.

Certain specialty drugs/ medical injectables require PA/precertification. To determine whether the medication you are prescribing requires PA/precertification, please refer to the Searchable Formulary or the Precertification Lookup Tool at <https://providers.anthem.com/nv>. If it is determined the medication you are seeking to prescribe requires PA/precertification, contact the Pharmacy Department at **844-396-2330**.

When prescribing a specialty drug, please fax your request to CarelonRx at **833-263-2871** or call CarelonRx at **833-262-1726**, and they will coordinate shipment to your office or to the member's home. You should not provide these drugs from your office stock without first obtaining precertification from us.

6.12 Behavioral Health Services

Members may self-refer, or you may direct members, to our network of behavioral healthcare providers for behavioral health services. We are responsible for the provision of mental health, alcohol use disorder and other drug use disorder assessments and treatment services as follows:

- Inpatient mental health and substance use disorder services
- Outpatient mental health and substance use disorder services
- Mental health rehabilitative treatment services
- Case management

- Residential treatment center (RTC) for adolescents

Medicaid/Nevada Check Up

We are responsible for reimbursement of all RTC charges including admission, bed day rate, and ancillary services.

Services for members diagnosed with Serious Emotional Disturbance and Serious Mental Illness

Our network providers must ensure members who are referred for evaluation for serious emotional disturbance (SED) or serious mental illness (SMI) populations, or who have been determined SED or SMI, are receiving covered medically necessary medical, outpatient or rehabilitative mental health services using an integrated wraparound model.

This model ensures the provision of biopsychosocial services based on an individual's needs and strengths, is family-driven, client-centered, and culturally competent. Services are provided according to a written individualized treatment plan, which contains measurable goals and objectives and includes access to an array of medically necessary outpatient mental health and rehabilitative mental health services across the continuum of care. Our network providers must ensure services are community based, provided in the least restrictive and most normative setting possible, and include effective care coordination.

Our network providers must ensure the parent or guardian of a minor member who is referred for SED assessment or an adult who is referred for SMI assessment is fully informed of the reason the assessment is necessary. You must obtain authorization from the minor member's parent or guardian or from the enrolled adult or their personal representative to conduct the assessment and to release the determination to us, the DHCFP and/or its designee. (Note: Policy regarding who the DHCFP recognizes as a personal representative is set forth in Chapter 3 of the *DHCFP HIPAA Privacy Manual*.)

Anthem and our designated subcontractors/network providers are the only entities with the authority to make the SED or SMI determination for our enrolled member. No other entity can make a determination on behalf of a Medicaid member enrolled with Anthem. If a non-designated entity makes a determination, Anthem will reject the determination and ask that the enrolled member be referred to Anthem for a determination and services. SED and SMI determinations made by authorized entities referenced in Chapters 400 and 2500 of the Nevada Medicaid Services Manual under Fee-For-Service (FFS) Medicaid will be considered valid for member who transition from FFS Medicaid to managed care. Likewise, determinations made by Anthem or our designated subcontractors/network providers will be considered valid for member who transition from managed care to FFS Medicaid. We will participate and have oversight of the transition of member from managed care to FFS Medicaid and have final review and determination. SED and SMI determinations made by appropriately licensed mental health practitioners within the 12-month period preceding initial Medicaid eligibility will be considered valid for either FFS Medicaid or managed care member and reviewed by Anthem for final determination.

Pursuant to the State of Nevada Title XIX State Plan, Medicaid member have the option of disenrolling from managed care on the 46th day, if determined to be SED or SMI, except in the case of admission to an RTC when disenrollment on the admission is mandatory. Pursuant to the Nevada Title XXI State Plan, in urban areas only, Nevada Check Up member must remain enrolled with the MCO responsible for ongoing patient care. When one of our members is determined to be SED or SMI and wishes to

disenroll from managed care, the Anthem provider who made the determination should complete the *Request for Managed Care Disenrollment Based on SED/SMI Determination* form.

Member who receives either an SED or SMI determination must be redetermined at least annually. For members who have voluntarily elected to remain enrolled in managed care, the process for these redeterminations is the same as for the initial SED or SMI determination as stated above.

Forms to obtain member consent for an SED/SMI evaluation, to document and notify DHCFP of an SED/SMI determination, and to enable the SED or SMI member to disenroll from Medicaid managed care are located on the [DHCFP website](#).

Within five business days, you are required to submit these forms to DHCFP per the instructions on the forms.

6.13 Medically Necessary Services

To be considered a medical necessity (medically necessary), items and services must have been established as safe and effective as determined by Nevada Medicaid service manuals and Nevada Check Up. The Nevada Medicaid Services Manual and Nevada Check Up determine that medically necessary items and services are:

- Consistent to diagnose, treat or prevent illness, injury, or disease
- To reduce or ameliorate effects of an illness, injury, or disability
- Required to regain or improve the ability to perform the activities and tasks of daily living
- Consistent with generally accepted professional medical standards.
- Not mainly for the convenience of the member, the provider, the member's family, or caregivers.
- Furnished at the most appropriate level that can be provided safely and effectively to the member; Medicaid will only cover items and services that are appropriate and necessary for the diagnosis or treatment of an illness or an injury or to improve the functioning of a malformed body part.
- Not for cosmetic purposes

Anthem will only cover items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or that improve the functioning of a malformed body part. Anthem does not cover procedures or medications that are experimental such as new treatments that are being tested or ones that have not been shown to work.

7 MEMBER RIGHTS AND RESPONSIBILITIES

Members have rights and responsibilities when participating with an MCO. Our Member Services representatives serve as advocates for our members. Members can find a list of these rights in the member handbook and on the member website at www.anthem.com/nvmedicaid. They can request a hard copy by calling Member Services at **844-396-2329** (TTY **711**). Below are our members' rights and responsibilities:

7.1 Member Rights

An Anthem member has the right to:

- Be treated with respect, dignity and have their right to privacy respected. This includes:
 - Knowing their medical records and discussions with their PCPs will be kept private and confidential.
 - Being treated fairly.
- Receive information about Anthem, its services, practitioners and providers, and member rights and responsibilities.
- Choose a practitioner who is part of the Anthem network and refuse care from specific PCPs and providers. This includes:
 - Knowing how to choose and change their health plan and PCP.
 - Choosing any health plan, they want that is available in their area and choosing their PCP from that plan.
 - Changing their PCP.
 - Selecting a specialist to serve as their PCP if they have a chronic condition.
 - Changing their health plan without penalty.
- Participate in the decision-making process for their healthcare. This includes:
 - Working as part of a team with their practitioner to decide what healthcare is best for them.
 - Taking part in an honest discussion on the proper or medically needed treatment options for their condition, without concern about the cost or benefit coverage.
 - Deciding on care recommended by their PCP and their other providers.
 - Being told and understanding the results of the decision.
 - Refusing treatment.
- Express and expect resolution of grievances and appeals about:
 - Anthem.
 - Our network PCPs and providers.
 - The care we provide.
- Create an advanced directive to tell their doctor the kind of care they want if they are not able to communicate their decisions.
- Have access to their medical records in agreement with all federal and state laws and be able to request the records be changed or corrected in agreement with federal and state laws.
- Make suggestions about the Anthem member rights and responsibilities policy.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Receive information on available treatment options and alternatives that is presented in a way that they are able to understand.
- Be free to exercise rights without Anthem or the provider treating the member adversely

7.2 Member Responsibilities

An Anthem member has the responsibility to:

- Provide information, the best they can, to help Anthem and our providers give them the best care, including:
 - Telling their practitioners about their health.
 - Talking to their practitioners about their healthcare needs and asking questions about the different ways healthcare problems can be treated.
 - Helping their practitioners get their medical records.
 - Providing their practitioners with the right information.
- Follow instructions and guidelines which they have agreed to given by Anthem, practitioners, and PCPs.
- Understand their health problems and work with their PCPs and providers to find an agreed upon plan to help treat their illness or condition, including:
 - Working as a team with their practitioners to decide what healthcare is best for them.
 - Understanding how what they do can affect their health.
 - Doing the best they can to stay healthy.
 - Treating PCPs and staff with respect.
- Notify Anthem if they have other health insurance.
- Carry their ID card at all times.
- Update demographic information with the Division of Welfare and Social Services.

7.3 Member Grievance

We have a grievance resolution process in place for our members. All members or persons acting on behalf of members have a right to voice dissatisfaction of any aspect of ours or a provider's operations. You can file a grievance on behalf of a member only after the member has granted you **written** permission to act as their personal representative. You must adhere to the same regulated time frames as we give the members.

Members are provided with the following information:

If you have a problem with our services or network providers, we would like you to tell us about it. Please call Member Services. We will try to solve your problem on the phone.

If we cannot take care of the problem when you call us, you can file a grievance. You can:

- File a grievance on the phone.
- Write a letter to us and include information, such as:
 - The date the problem happened.
 - The names of people involved.
 - Details about the problem.
- Ask Member Services for help with writing a letter; include information such as the date the problem happened, details about the problem and the people involved.

- Send your letter to:

Anthem Blue Cross and Blue Shield Healthcare Solutions
Desert Canyon Building 9
9133 W. Russell Road
Las Vegas, NV 89148

When we get your grievance by call or letter, we will:

1. Send you a letter within five calendar days to let you know we received your grievance.
2. Look into your grievance in a timely manner.
3. Send you a letter within 90 calendar days of when you first told us about your grievance; the letter will advise you of our decision. If urgent, we will send you a letter and will try to call you to give notice of your grievance.

7.4 Authorization and Notice Timeliness Requirements

We will provide standard authorization decisions as expeditiously as the member's health requires and within the State's established timelines that will not exceed 14 calendar days following receipt of the prior authorization request for service, with a possible extension of up to 14 additional calendar days if you or the member request the extension or Anthem justifies to the DHCFP a need for additional information and how the extension is in the member's interests.

For cases in which a provider indicates or we determine that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, we will make an expedited authorization decision and provide a notice of action as expeditiously as the member's health condition warrants and no later than 72 hours after receipt of the request for service.

We may extend the 72-hour time period by up to 14 calendar days if the member requests an extension or if we justify to the DHCFP a need for additional information and how the extension is in the member's interests.

7.5 Notice of Action: Adverse Benefit Determination

We will provide a written notice of action to the member and provider when we make an Adverse Benefit Determination affecting the member.

To ensure ease of understanding by non-English speaking or visually impaired members or members with limited reading proficiency, the written notice to the member must meet the language and format requirements of *42 CFR 438.101* and (d).

A written notice of action to the member contains the following:

- The action we or our subcontractor has taken or intends to take
- The reasons for the action
- Your or the member's right to file an appeal

- The member's right to request a state fair hearing after the member has exhausted our internal appeal procedures
- The procedures for exercising the member's rights to appeal
- The circumstances under which expedited resolution is available and how to request it
- The member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued and the circumstances under which the member may be required to pay the costs of these services
- The member's right to represent himself or use legal counsel, a relative, a friend or other spokesperson
- The specific regulations that support the action or the change in federal or state law that requires the action

We must give notice at least 10 days before the date of action when the action is a termination, suspension, or reduction of previously authorized covered services. This time frame may be shortened to five days if probable member fraud has been verified.

We must give notice by the date of the action for the following circumstances:

- The death of the member
- A signed written member statement requesting termination or giving information requiring termination or reduction of services (where the member understands that this must be the result of supplying that information)
- The member's admission to an institution where they are ineligible for further services
- The member's address is unknown, and mail directed to them has no forwarding address
- The member has been accepted for Medicaid services by another local jurisdiction
- The member's physician prescribes the change in level of medical care
- An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions
- The safety or health of individuals in the facility would be endangered, the health of the resident improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs, or the resident has not resided in the nursing facility for 30 days (applies only to adverse action for nursing facility transfers)

It is necessary that we give a notice of action on the date of action when the action is a denial of payment.

We must give notice on the date that the time frames expire when service authorization decisions are not reached within the time frames for either standard or expedited service authorizations. Untimely service authorizations constitute a denial and are thus adverse actions.

These notices must include:

- The member's right to file an appeal if they disagree with that decision.
- The member's right to receive written resolution notice. In addition, reasonable efforts will be made to provide oral resolution notice.

7.6 Medical Necessity Appeals

If you or the member do not agree with the adverse determination of medically necessary services made by Anthem, an appeal can be filed. Medical necessity appeals must be filed within 60 calendar days

from the date on the Notice of Action. You may appeal on behalf of the member as long as you have received written permission from the member.

The Provider Appeal Request Form is available on the provider website under Forms section. If you are submitting an appeal on behalf of a member, you must obtain written permission from the member and submit your appeal with the member's written consent. Without written permission from the member, your appeal could result in delay or dismissal of your appeal.

Complete the appeal request form and send it to:

Anthem Blue Cross and Blue Shield Healthcare Solutions
Appeals Department
P.O. Box 62429
Virginia Beach, VA 23466-2429
FAX: 888-235-9334

We will process and resolve each medical necessity appeal and provide notice as expeditiously as the member's health condition requires within the time frames specified as follows:

- **Standard resolution of appeals:** 30 calendar days from the date of receipt of the appeal. An oral appeal can be filed by contacting Provider Services at **844-396-2330**. The date the oral appeal is filed with Member Services will be used in calculating the resolution time period.
- **Expedited resolution of appeals:** 72 hours from the date of receipt of the appeal. For cases in which a provider indicates that following the standard time frame could seriously jeopardize the member's life or health, or ability to attain, maintain or regain maximum function, we request that you contact Provider Services at **844-396-2330** for assistance in submitting your appeal.
- If we deny a request for **expedited** resolution of an appeal, we will transfer the appeal to the standard resolution time of appeals. We make reasonable efforts to give the member oral notice of resolution of an expedited appeal and follow up within two calendar days with a written notice to let the member know how the decision was made and how they can file a grievance if they do not agree with the decision. We ensure that punitive action is not taken against a provider who supports an expedited appeal.

We are required to inform the member of the limited time available to present evidence and allegations of fact or law, in person or in writing, in the case of the expedited resolution.

These time frames may be extended up to 14 calendar days if the member requests such an extension or we demonstrate to the satisfaction of the DHCFP the need for additional information and how the extension is in the member's interests. If DHCFP grants us a request for an extension, we must give the member written notice of the reason for the delay within two calendar days with the reason for the delay. A reasonable attempt to provide prompt oral notice will also be made, in addition to the written notice. If the member is not happy with the extra time, we need to complete the review, the member can file a grievance about the delay.

We will notify the member and provider of the disposition of appeals in writing. We will tell you our decision within 30 calendar days from when we received your appeal or within 72 hours if you asked for an expedited appeal. We will also try to call you to provide oral notice of the resolution of the appeal. The written notice must include the results of the resolution process and the date it was completed. For appeals that are not wholly resolved in favor of the member, the notice must also state:

- The right of the member to request a state fair hearing from the DHCFP and how to do so.
- The right to request to receive benefits while the hearing is pending and how to make this request.
- The possibility the member may be held liable for the cost of those benefits if the state fair hearing officer upholds our action.

7.7 Continuation of Benefits during Appeals or State Fair Hearings

While our appeal process and the state fair hearing are pending, we must continue the member's benefits if all of the following conditions exist:

- The appeal is submitted to us on or before the later of the following: within 10 days of our mailing the Notice of Adverse Benefit Determination or the intended effective date of our proposed Adverse Benefit Determination.
- The member files the request for an appeal within sixty (60) calendar days following the date on the Adverse Benefit Determination notice.
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- The services were ordered by an authorized provider.
- The original periods covered by the original authorization have not expired.
- The member requests an extension of benefits.

If at the member's request we continue the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

- The member withdraws the appeal.
- 10 calendar days pass after we mail the notice of action, providing the resolution of the appeal against the member, unless the member within the 10-calendar day time frame has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached.
- A State Fair Hearing Officer issues a hearing decision adverse to the member.
- The time period of service limits of a previously authorized service has been met.

If the final resolution of the appeal is adverse to the member, we may recover the cost of the services furnished to the member while the appeal was pending, to the extent they were furnished solely because of the requirements of this section and in accordance with policy set forth in 42 CFR 431.230(b).

If Anthem or State Fair Hearing Officer reverses an action to deny, limit or delay services that were not furnished while the Appeal was pending, Anthem must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than seventy-two (72) hours from the date Anthem receives notice reversing the determination. If Anthem or State Fair Hearing Officer reverses a decision to deny authorization of services, and the Member received the disputed services while the Appeal was pending, Anthem must pay for those services.

7.8 Member State Fair Hearing Process

We will inform the member of their right to a State Fair Hearing and how to obtain such a hearing. In addition, we must explain representation rules to the member and provided by Anthem pursuant to 42 CFR 431.200(b); 42 CFR 431.220(5); 42 CFR 438.414; and 42 CFR 438.10(g) (1).

Members are informed of the following:

You have the right to ask for a State Fair Hearing from the State after the Anthem appeal process has been exhausted. Or, if we fail to review your appeal within 30 calendar days for a standard request or within 72 hours for an expedited request as you are deemed to have exhausted Anthem's appeal process and may ask for a State Fair Hearing. You may ask for a State Fair Hearing within 90 calendar days from the date of the appeal denial letter saying we denied coverage of services.

Nevada Medicaid and Check Up members can ask for a State Fair Hearing by completing and sending the Member State Fair Hearing form Anthem sent with the denial notice. Or members can send a letter asking for a State Fair Hearing along with the Anthem denial notice to:

Nevada Division of Health Care Financing and Policy Hearings
1100 E. William St., Suite 102
Carson City, NV 89701

If you have any questions about your rights to request a fair hearing, call Anthem Member Services. Or if you have questions regarding the fair hearing, you may call the hearings supervisor at **702-486-3000**, ext. **43604**, in the Las Vegas area or **775-684-3604** if you live in the Carson City area. Or call the toll-free number: **800-992-0900**, ext. **43604**.

If you ask for a State Fair Hearing, you will get a letter from the State telling you the date and time of a hearing preparation meeting. The hearing preparation meeting will be held by phone, and you can explain why you disagree with the decision made by Anthem. If you proceed to a State Fair Hearing, you must attend the fair hearing in person unless you get the hearing officer's consent to attend by phone. You do not have to pay any costs to take part in the hearing.

Expedited State Fair Hearing: If a recipient sends in a State Fair Hearing request to the DHCFP with clinical documentation that supports the urgency of the request and requests the **hearing to be expedited**, the Hearings Unit will send the clinical documentation for medical review by an impartial, third-party physician. If the physician determines the time otherwise permitted for a **standard fair hearing** decision — 60 days — could jeopardize the individual's life, health, or ability to attain, maintain or regain maximum function, a hearing decision will be issued within three working days. The MCO clinician (physician) and MCO attorney will need to represent themselves at the expedited fair hearing as is the current process for **standard fair hearings**. The expedited fair hearings are all held telephonically due to time constraints. If the recipient does not receive an expedited fair hearing, the hearing request will be treated as a standard fair hearing request. The member request for state fair hearing form can be found on the provider website.

8 FRAUD, WASTE, AND ABUSE

8.1 First Line of Defense Against Fraud and Abuse

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 health care. 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

Presentation of a member identification (ID) card does not guarantee eligibility; providers should verify a member's status by inquiring online or via telephone. Online support is available for provider inquiries on the website, and telephonic verification may be obtained through the automated Provider Services at **844-396-2330**.

Providers should encourage members to protect their ID cards as they would a credit card, to carry their health benefits card at all times, and report any lost or stolen cards to the company as soon as possible. Understanding the various opportunities for fraud and working with members to protect their health benefit ID card can help prevent fraudulent activities. If you or a patient suspect member ID theft, call the compliance hotline at **757-518-3633**. Providers should instruct their patients who suspect member ID theft to inspect their *Explanation of Benefits (EOBs)* for any errors and then contact Member Services if something is incorrect.

8.2 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 reporting the incident and their callback number will be kept in strict confidence by investigators.

You can report your concerns by:

- Visiting our website and completing the “**Report Waste, Fraud and Abuse**” and click on ‘Report It’ and complete the fraud referral form
- Calling Provider Services at **844-396-2330**
- Calling our Special Investigations Unit fraud hotline at **866-847-8247**

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 letting us know
- 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

8.3 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 the 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 or further legal action.

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

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.

8.4 Relevant Legislation

False Claims Act

We are committed to complying with all applicable federal and state laws, including the federal *False Claims Act (FCA)*. The *FCA* is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the *FCA*, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages or loss to the government, plus civil penalties of \$5,500 to \$11,000 per false claim.

The *FCA* also contains Qui Tam or *whistleblower* provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government, or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under Qui Tam provisions in the *FCA* and may be entitled to a percentage of the funds recovered by the government.

HIPAA

The *Health Insurance Portability and Accountability Act (HIPAA)* was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of healthcare fraud, and simplifies the administration of health insurance.

We strive to ensure both Anthem and contracted participating providers conduct business in a manner that safeguards patient/member information in accordance with the privacy regulations enacted pursuant to *HIPAA*. Contracted providers are mandated to have appropriate procedures implemented to demonstrate compliance with the *HIPAA* privacy regulations.

We recognize our responsibility under the *HIPAA* privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose. Conversely, you should only request the minimum necessary member information required to accomplish the intended purpose when contacting us. However, please note that the privacy regulations allow the transfer or sharing of member information, which may be requested by Anthem to conduct business and make decisions about care, such as a member's medical record, to make an authorization determination or resolve a payment appeal. Such requests are considered part of the *HIPAA* definition of treatment, payment, or healthcare operations.

Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with access restricted to individuals who need member information to perform their jobs. When faxing information to us, verify that the receiving fax number is correct, notify the appropriate staff at Anthem and verify that the fax was appropriately received.

Email (unless encrypted) should not be used to transfer files containing member information to us (for example, Excel spreadsheets with claim information). Such information should be mailed or faxed.

Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked confidential and addressed to a specific individual, P.O. Box, or department at Anthem.

Our voicemail system is secure and password protected. When leaving messages for our associates, you should only leave the minimum amount of member information required to accomplish the intended purpose.

When contacting us, please be prepared to verify the provider's name, address, NPI number, and tax identification number (TIN) or Anthem provider number.

9 MEMBER MANAGEMENT SUPPORT

9.1 Welcome Call

As part of our member management strategy, we offer a welcome call to new members. During the welcome call, new members are educated regarding the health plan and available services. They also offer to assist the member with any current needs such as scheduling an initial checkup or clarifying benefits under their plan.

9.2 Appointment Scheduling

Through our participating providers, we ensure members have access to primary care services for routine, urgent and emergency services and to specialty care services for chronic and complex care. You are expected to respond to our member's needs and requests in a timely manner. The PCP/PCS should make every effort to schedule our members for appointments using the guidelines in the [PCP/PCS Access and Availability](#) section.

9.3 24/7 NurseLine

Our 24/7 NurseLine is a service designed to support the provider by offering information and education about medical conditions, healthcare, and prevention to members after normal physician practice hours. The 24/7 NurseLine provides triage services and helps direct members to appropriate levels of care. The 24/7 NurseLine phone number is **844-396-2329** (TTY **711**) and is listed on the member's ID card. This ensures members have an additional avenue of access to healthcare information when needed. Features of the 24/7 NurseLine include the following:

- Constant availability: 24 hours a day, 7 days a week
- Information based on nationally recognized and accepted guidelines
- Free translation services for 170 different languages and for members with difficulty hearing
- Education for members about appropriate alternatives for handling nonemergent medical conditions

The nurse will fax the member's assessment report to the provider's office within 24 hours of receipt of the call.

9.4 Interpreter Services

Interpreter services are available if needed. Anthem partners with CulturalLink, which provides interpretative services for language and hard of hearing (deaf). Our relationship with this company assists in improving patient-centered care and creating an effective, diverse workforce through services focused on diversity, inclusion, and cultural competence. They provide hundreds of healthcare providers with best-in-class consulting along with comprehensive translation and interpretation in more than 200 languages with 24/7 service. Providers can reach CulturalLink for services at **888-844-1414**.

Members who are deaf or hard of hearing should call the toll-free AT&T Relay Service at TTY **711** (**844-396-2329**) at least five days before the scheduled appointment.

9.5 Health Promotion

We strive to improve healthy behaviors, reduce illness, and improve the quality of life for our members through comprehensive programs. Educational materials are developed or purchased and disseminated to our members and network providers who are contracted with Anthem.

We manage projects that offer our members education and information regarding their health. Ongoing projects include:

- A semiannual member newsletter
- Creation and distribution of Health Tips, the Anthem health education tool used to inform members of health promotion issues and topics
- Health Tips on Hold (educational telephone messages while the member is on hold)
- Relationship development with community-based organizations to enhance opportunities for members

9.6 Care Management

Care management is designed to respond proactively to a member's needs when conditions or diagnoses require care and treatment for extended periods of time. When a member is identified (usually through predictive modeling, precertification, admission review and/or provider or member request), the member is assigned to a care manager — an Anthem clinician — who helps identify medically appropriate alternative methods or settings in which care may be delivered.

You, on behalf of the member, may request participation in the program. The care manager will work with the member, you and/or hospital to identify the:

- Intensity level of care management services needed.
- Appropriate alternate settings where care may be delivered.
- Healthcare services required.
- Equipment and/or supplies required.
- Community-based services available.
- Communication required (for example, between member and PCP/PCS).

The care manager will assist the member, utilization review team and PCP/PCS/hospital in developing the plan of care, ensuring the member's medical needs are met, and linking the member with community resources and Anthem programs for outpatient care management and/or disease management.

Comprehensive Member Assessment

A case manager will conduct a comprehensive assessment to further determine members' needs. The assessment will include a range of questions that identify and evaluate the member's medical and behavioral health condition, social determinants of health, functional status, emotional status, capability for self-care and the current treatment plan goals.

Using the structured online assessment tool, case managers will conduct telephone interviews or face-to-face visits to collect and assess information from the members or their representatives. To complete the assessment, case managers may obtain information from the PCPs/PCSs and specialists, our continuous case finding information and other sources to coordinate and determine current medical needs and needed nonmedical services.

As a result of the assessment process members are stratified into Tier 1 or Tier 2 Care Management. Tier 1 allows for care coordination which is designed to assist those Members with social determinants of health needs (SDOH) challenges to accessing health and community resources, or other needs that fragment Member care or lead to poor health outcomes. Tier 2 is considered high level Case Management and provided for members identified as high risk and/or with complex needs. These cases are managed by licensed clinical professionals.

Individualized Plan of Care

Case managers will use information from the assessment to determine appropriateness of Care Management services and guide, develop and implement a person-centered care plan in collaboration with the member, their family, and the member's provider. Our experience has shown that members are more likely to comply with treatment planning if they are empowered to make their own healthcare decisions.

Case managers will consider member needs for social, educational, therapeutic, and other nonmedical support services such as personal care, WIC, and transportation vendors, as well as the strengths and needs of the family. When nonmedical needs are extensive or complex, case manager clinicians will collaborate with case manager social workers and our social drivers of health (SDOH) program managers. Case managers will also coordinate with member advocates or outreach associates to contact difficult-to-reach members and coordinate with community resources. Members that have been identified with special healthcare needs (SHCN), where the complex health condition is expected to last more than 1 year, will be perpetually managed by a case manager.

If a member is already receiving care management services from another entity, such as a community services organization, the plan will define processes for coordinating medical, mental health and substance abuse, and social service components of care management and the roles of each team. Case managers will collaborate with PCPs/PCs and specialists to ensure the plans of care support the provider medical plans. Case managers will forward written care plans to practitioners via fax, email, or mail. The plan of care should be reviewed/revise, signed and returned to the case manager.

Children with Special Healthcare Needs (CSHCN)

Children who have, or at risk for, chronic physical, developmental, behavioral, or emotional conditions; and also require health and related services of a type and amount beyond that required by children in general; and are receiving services through family-centered, community-based, coordinated care systems receiving grant funds, under *Section 501 (a)(1)(D) of Title V of the Social Security Act* (known as Nevada Early Intervention Program); or children self-identified by parents/guardians as potentially having special healthcare needs. Case management will outreach to these families as they are referred to Anthem or are identified via screenings.

9.7 Integrated Medical Management Model (IM³)

We will provide a member-centric care management approach customized to the individual's needs, the diagnosis and prognosis, the care environment, and available treatment alternatives. The components of our approach, which is defined through an integrated medical management model (IM³), include continuous monitoring and evaluation.

Our continuous case finding (CCF) methodology guides performance of a number of ongoing analyses that identify and prioritize existing members for care management referral as needed. We typically identify catastrophic cases during daily rounding on the inpatient census, monitoring each case on admission and when a member's situation changes. A prioritized list of high-risk members with their Chronic Illness Intensity Index, our proprietary predictive model that factors in manageable physical and behavioral health conditions that drive cost and utilization specific to each of these populations (Medicaid and Nevada Check Up), is generated monthly using multiple data sources. This list assigns each member to a management group based on their score, so members who are at highest risk are flagged for immediate care management by an interdisciplinary team. This algorithm also allows identification of members for Condition Care programs. Medical management nurses use their clinical expertise to identify members with health factors, such as chronic or comorbid illness or social determinant of health issues, who would benefit from care coordination services.

Our care management staff will routinely conduct systematic review of paid claims, encounter, utilization, and pharmacy data, as well as daily census reports, to gain a full picture of members identified for case management. We will interface with the pharmacy benefits manager to identify candidates for case management based on drug utilization and defined thresholds. Additionally, release from the inpatient setting can be an automatic trigger for care management.

9.8 Condition Care

Condition Care (CNDC) programs are based on a system of coordinated care management interventions and communications designed to assist physicians and others in 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 member population.

Earning National Committee for Quality Assurance (NCQA) Population Health Program accreditation is an indication that the condition care program is dedicated to giving patients and practitioners the systems support, education, and other help necessary to ensure good outcomes and good care.

Our condition care programs include:

- Behavioral health (Severe Mental Illness):
 - Bipolar disorder
 - Schizophrenia
 - Substance use disorder
 - Major depressive disorder – adult and child/adolescent
- Cardiac:
 - Coronary artery disease (CAD)
 - Congestive heart failure (CHF)
- Diabetes
- Hypertension
- HIV/AIDS
- Pulmonary:
 - Asthma
 - Chronic obstructive pulmonary disease (COPD)

In addition to our condition-specific condition care programs, our member-centric, holistic approach also allows us to assist members with smoking and weight management education.

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 patient self-management education including primary prevention, coaching on healthy behaviors and compliance/monitoring, and case/care management for high-risk members
- Ongoing communication with primary and ancillary providers regarding patient status
- Nine of our Condition Care programs are National Committee for Quality Assurance (NCQA) accredited and incorporate outreach, education, care coordination and follow-up to improve treatment compliance and enhance self-care.

Additionally, all our programs are based on nationally approved clinical practice guidelines located at <https://providers.anthem.com/nv>.

Who Is Eligible?

Member diagnosed with one or more of the above conditions are eligible for CNDC services.

As a valued provider, we welcome your referrals of patients who can benefit from additional education and care management support. Our care managers will work collaboratively with you to obtain your input in the development of care plans. Members identified for participation in any of the programs are assessed and risk stratified based on the severity of their condition. They are provided with continuous education on self-management concepts, which include primary prevention, coaching related to healthy behaviors and compliance/ monitoring, as well as care/case management for high-risk members. Providers are given phone and/or written updates regarding patient status and progress.

CNDC Provider Rights and Responsibilities

You have the right to:

- Have information about us, including provided programs and services, our staff and our staff's qualifications and any contractual relationships.
- Decline to participate in or work with our programs and services for your patients.
- Be informed of how we coordinate our interventions with treatment plans for individual patients.
- Know how to contact the person responsible for managing and communicating with your patients.
- Be supported by us to make decisions interactively with patients regarding their healthcare.
- Receive courteous and respectful treatment from our staff.
- Communicate complaints regarding CNDC as outlined in our provider complaint and grievance procedure.

Contact Information

Email us at Condition-Care-Provider-Referrals@anthem.com anytime or call **888-830-4300** from 8:30 a.m. to 5:30 p.m. Pacific time, Monday through Friday, to reach a CNDC staff member. Confidential voicemail is available 24 hours a day.

9.9 Member Advisory Board

The Member Advisory Board provides advice to us regarding health education and outreach program development. The Member Advisory Board strives to ensure materials and programs meet cultural

competency requirements, are easily understood by members, and address the health education needs of the member. Anthem provides opportunities for members from various demographics and backgrounds to participate.

The responsibilities of the Member Advisory Board are to:

- Identify health education needs of the membership based on review of demographic and epidemiologic data.
- Identify cultural values and beliefs that must be considered in developing a culturally competent health education program.
- Assist in the review, development, implementation, and evaluation of the member health education tools for the outreach program.
- Review the health education plan and making recommendations on health education strategies.
- Identify health equity issues that Anthem should consider in its program and product development.
- Assist the plan in decision making in the areas of member grievances, marketing, member services, case management, outreach, health needs and cultural competency.
- Provide input into the annual review of policies and procedures, QM program results and outcomes, and future program goals and interventions.

10 PROVIDER RESPONSIBILITIES

10.1 Medical Home

The PCP/PCS is the foundation of the collaborative concept known as a medical home. They are responsible for providing, managing, and coordinating all aspects of the member's medical care and providing all care that is within the scope of their practice. The PCP/PCS is also responsible for coordinating member care with specialists and conferring and collaborating with specialists.

We promote the medical home concept to all of our members. The PCP/PCS is the member and family's initial contact point when accessing healthcare. The PCP's/PCS's relationship with the member and family, together with the healthcare providers within the medical home and the extended network of consultants and specialists with whom the medical home works, have an ongoing and collaborative contractual relationship. Providers in the medical home are knowledgeable about the member's and family's special, health-related social and educational needs and are connected to necessary resources in the community that will assist the family in meeting those needs. When a member is referred for a consultation or specialty/hospital services or health and health-related services by the PCP/PCS through the medical home, the medical home provider maintains the primary relationship with the member and family. They keep abreast of the current status of the member and family through a planned feedback mechanism with the PCP/PCS who receives them into the medical home for continuing primary medical care and preventive health services.

10.2 Responsibilities of the PCP/PCS

The PCP is a network physician who has responsibility for the complete care of their members, whether providing it on their own or by referral to the appropriate provider of care within the network. FQHCs and RHCs may be included as PCPs. Below are highlights of the PCP's/PCS's responsibilities.

The PCP/PCS shall:

- Be responsible for the delivery of covered Medically Necessary primary care services and preventive services, including EPSDT screening services and Well Baby/Child Services
- Manage the medical and healthcare needs of members, including: monitoring and following up on care provided by other providers (including FFS); providing continuity and coordination of member's healthcare; referrals for specialty care and other covered Medically Necessary services in the managed care benefit package; and maintaining a current medical record for the member, including documentation of all services rendered by the PCP/PCS, specialty or Referral services, or Out-of-Network services such as Family Planning and Emergency Services.
- Allow and educate members about their ability to self-refer for family planning (in or Out-of-Network), and obstetrical, gynecological, mental health and substance abuse services within Anthem's Network
- Ensure to include a signed Acknowledgment of Patient Information on Advance Directives (<http://dhcfnv.gov/Resources/PI/AdvanceDirectives>) and/or maintain the member's up-to-date executed living will or advance directive in the member's medical chart.
- Provide 24-hour coverage 7 days a week; regular hours of operation should be clearly defined and communicated to members.
- Provide services ethically and legally and in a culturally competent manner, meeting the unique needs of members with special healthcare needs.

- Participate in any system we establish to facilitate the sharing of records, subject to applicable confidentiality and *HIPAA* requirements.
- Make provisions to communicate in the language or fashion primarily used by their membership.
- Participate and cooperate with us in any reasonable internal and external quality assurance, utilization review, continuing education, and other similar programs we establish.
- Participate and cooperate in HEDIS and Risk Adjustment audits conducted by Anthem.
- Participate in and cooperate with our complaint and grievance procedures when notified by us of a member grievance.
- Not balance-bill members.
- Continue care in progress during and after termination of their contract for up to 60 calendar days 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.
- Fill out the maternity risk screen, which can be found on the provider website during the first office visit and return it to us via fax at **800-964-3627** in order to identify members who would benefit from OB case management and participate in our New Baby, New LifeSM program.
- Comply with all applicable federal and state laws regarding the confidentiality of patient records.
- Develop and have 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.
- Support, cooperate and comply with our Quality Improvement Program initiatives and any related policies and procedures to provide quality care in a cost-effective and reasonable manner.
- Inform us if a member objects to provision of any counseling, treatments, or referral services for religious reasons.
- Treat all members with respect and dignity, provide members with appropriate privacy, and treat member disclosures and records confidentially, giving members the opportunity to approve or refuse their release.
- Provide to members complete information concerning their diagnoses, evaluations, treatments, and prognoses and give members the opportunity to participate in decisions involving their healthcare, except when contraindicated for medical reasons.
- Advise members about their health status, medical care, or treatment options, regardless of whether benefits for such care are provided under the program and advise members on treatments that may be self-administered.
- Contact members as quickly as possible when clinically indicated for follow-up regarding significant problems and/or an abnormal laboratory or radiological finding.
- Freely communicate with the members about their treatment, regardless of benefit coverage limitations; the practitioner will in no way be discouraged or inhibited from doing this.
- Have a policy and procedure to ensure proper identification, handling, transport, treatment, and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.
- Agree to maintain communication with the appropriate agencies such as local police, social services agencies, and poison control centers to provide high-quality patient care.
- Agree that any notation in a member's clinical record indicating diagnostic or therapeutic intervention as part of the clinical research shall be clearly contrasted with entries regarding the provision of care not related to research.
- Complete Certification Statement for Abortion to Save the Life of the Mother and/or a Certification Statement for Abortion due to Sexual Assault (Rape) or Incest when applicable; the forms can be found here: <https://www.medicaid.nv.gov/providers/forms/forms.aspx>.

- Communicate a member's coordination of care between specialists and PCPs/PCSs.
- Limit a member's waiting time to no more than one hour from the scheduled appointment time, except when you are unavailable due to an emergency; you are allowed to be delayed in meeting scheduled appointment times when you work in urgent cases or if a serious problem is found, or the patient has an unknown need that requires more services or education than was described at the time the appointment was scheduled.

PCP/PCS responsibilities for the initial newborn examination and subsequent care until discharge include the following:

- The initial physical examination done in the delivery room must be a rapid screening for life threatening anomalies that may require immediate billable attention.
- Complete physical examination must be done within 24 hours of delivery but after the six-hour transition period when the infant has stabilized; this examination is billable.
- Brief examinations should be performed daily until discharge; on day of discharge, physician may bill either the brief examination or discharge day code, not both.
- In accordance with NRS 442.540, all newborns must receive hearing screenings; this testing and interpretation are included in the facility's per diem rate.

No prior authorization is required when circumcision is performed up to 1 year of age. If a newborn is discharged less than 24 hours after delivery, we will reimburse newborn follow-up visits in the physician's office up to four days post-circumcision.

Continuity of Care

It may be necessary to transfer a member from Anthem to another MCO or to FFS for a variety of reasons. When notified that a member has been transferred to another MCO or to FFS, you must have written policies and procedures for transferring relevant patient information, medical records, and other pertinent materials to the other plan or FFS provider.

Prior to transferring a member, you must send the receiving plan or provider information regarding the member's condition. This information will include the name of the assigned PCP/PCS and the following information without limitation as to whether the member is:

- Hospitalized.
- Pregnant.
- Receiving dialysis.
- Chronically ill (for example, diabetic, hemophilic, etc.).
- Receiving significant outpatient treatment and/or medications, and/or pending payment authorization request for evaluation or treatment.
- On an apnea monitor.
- Receiving behavioral or mental health services.
- Involved in or pending authorization for major organ or tissue transplantation.
- Scheduled for surgery or postsurgical follow-up on a date subsequent to transition.
- Scheduled for pre-certified procedures and/or therapies on a date subsequent to transition.
- Referred to a specialist(s).
- Receiving substance abuse treatment if the member is 21 or older.
- Receiving prescription medications.
- Receiving durable medical equipment or currently using rental equipment.
- Currently experiencing health problems.
- Receiving case management (including the case manager's name and phone number).

Nevada Early Intervention Services, in accordance with an individualized family service plan (IFSP), provides a case manager who assists in developing a plan to transition the child to the next service delivery system. For most children this would be the school district, and services are provided for the child through an individual education program (IEP).

When a member is transferred to you from another MCO or FFS, you should request medical records and other pertinent materials from the former provider.

When a member changes MCOs or reverts to FFS while hospitalized, we will notify the receiving MCO, the receiving provider or the DHCFP Quality Improvement Organization (QIO), as appropriate, of the change within five calendar days.

New Members Who are Pregnant

A pregnant woman who enrolled with us while pregnant must be allowed to remain in the care of a non-network provider if at all possible.

10.3 PCP/PCS Access and Availability

All providers are expected to meet the federal and state accessibility standards and those defined in the Americans with Disabilities Act of 1990. Healthcare services provided through us must be accessible to all members. At least once a year, an Anthem vendor will conduct a survey to ensure providers are adhering to Anthem access standards.

We are dedicated to arranging access to care for our members. Our ability to provide quality access depends upon the accessibility of network providers. You are required to adhere to the following access/appointment standards:

Type of Care	Standard
After-hours access	Members must have access to communicate with provider after hours. See below for details.
Urgent care PCP appointment	Same day
Medically Necessary PCP appointment	Within two calendar days
Routine care PCP appointment	Within two weeks. This does not apply to regular visits to monitor chronic condition if condition requires more frequent visits.

You may not use discriminatory practices such as preference to other insured or private-pay patients, fewer operating hours, separate waiting rooms or appointment days.

We will routinely monitor provider adherence to the access-to-care standards. To ensure after-hours coverage, PCPs/PCSs must maintain one of the following arrangements for members to contact them after normal business hours:

- To ensure continuous 24-hour coverage, PCPs/Primary Care Specialists (PCSs) must maintain one of the following arrangements for members to contact them after normal business hours.
- Have the office telephone answered after hours by an answering service that can contact the PCP/PCS or another designated network medical practitioner or instructs the member that the provider will contact the member back by the next business day.

- Have the office telephone answered after normal business hours by a recording in the language of each of the major population groups served by the PCP/PCS informing the member of the process for reaching a provider after hours.
- Have the office telephone transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP/PCS or a designated the health plan network medical practitioner who will contact the member back by the next business day.
- For emergent issues, both the answering service and answering machine will direct the member to call **911** or go to the nearest emergency room.

The following telephone answering procedures are not acceptable:

- Office telephone is only answered during office hours.
- Office telephone is answered after hours by a recording that directs members to go to an ER for any services needed.
- A telephonic after- hours survey will be conducted by Provider Relations or vendor utilizing the following criteria:
 - Direct contact with provider or health care professional.
 - Answering Service with ability to triage by health care professional, page on-call provider or page to requested provider.
 - Answering Machine that pages provider or health care professional, provides instructions on how to do so, or instructs member to go to the emergency room or urgent care, if he/she is unable to wait until the next business day.

For urgent care and additional after-hours care information, see the [Urgent Care/After-hours Care](#) section.

10.4 Member Missed Appointments

Our members may sometimes cancel or not appear for necessary appointments and fail to reschedule the appointments. This practice can be detrimental to their health. We require you to attempt to contact any member who has not shown up for or canceled an appointment without rescheduling the appointment. The contact must be by telephone and should be designed to educate the member about the importance of keeping appointments and to encourage the member to reschedule the appointment. If the member has missed too many appointments, you may ask the member to be assigned to another PCP. You may not charge the member a fee for any missed appointments. Please ask the member to call Anthem Member Services at **844-396-2329** (TTY **711**) for help in locating a PCP.

Our members who frequently cancel or fail to show up for appointments without rescheduling may need additional education in appropriate methods of accessing care. In these cases, please call Provider Services at **844-396-2330** to address the situation. Our staff will contact the member and provide more extensive education and/or case management as appropriate. Our goal is for members to recognize the importance of maintaining preventive health visits and to adhere to a plan of care recommended by their PCPs/PCSs.

10.5 Noncompliant Anthem Members

We recognize you may need help in managing noncompliant members. If you have an issue with a member regarding behavior, treatment cooperation and/or completion of treatment and/or making or appearing for appointments, please contact Provider Services at **844-396-2330**. Our staff will contact the member and provide more extensive education and/or case management as appropriate.

10.6 PCP/PCS Transfers

To maintain continuity of care, we encourage members to remain with their PCPs/PCSs. However, members may request to change their PCP/PCS for any reason by contacting our Member Services department at **844-396-2329** (TTY **711**). The member's name will be provided to the PCP/PCS on the membership roster.

Members can call to request a PCP/PCS change any day of the month. PCP/PCS change requests will be processed generally on the same day or by the next business day. New member ID cards will be mailed within five business days.

10.7 Covering Physicians

During an absence or unavailability, you will need to arrange for coverage of your members. You will either: 1) make arrangements with one or more network providers to provide care for your members or 2) make arrangements with another similarly licensed and qualified provider who has appropriate medical staff privileges at the same network hospital or medical group, as applicable, 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 without limitation any applicable limitations on compensation, billing, and participation. You will be solely responsible for a non-network provider's adherence to such provisions. You will be solely responsible for any fees or monies due and owed to any non-network provider providing substitute coverage to a member on your behalf.

10.8 Specialist as a PCP/PCS

We contract with a network of provider specialty types to meet the medical specialty needs of members and provide all medically necessary covered services.

Under certain circumstances, when a member requires the regular care of the specialist, we may approve a specialist to serve as a member's PCP/PCS. The criteria for a specialist to serve as a member's PCP/PCS include the member having a disability or a chronic condition of such complexity whereby:

- The need for multiple hospitalizations exists.
- The majority of care needs to be given by a specialist.
- The administrative requirements arranging for care exceed the capacity of the non-specialist PCP/PCS. This would include members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex hematology/oncology conditions, cystic fibrosis, etc.

The specialist must meet the requirements for PCP/PCS participation (including contractual obligations and credentialing), provide access to care 24 hours a day, 7 days a week, and coordinate the member's healthcare, including preventive care. For further information, see the Specialist as PCP/PCS Request Form located on the provider website.

10.9 Reporting Changes in Address and/or Practice Status

For any demographic changes, please use Provider Data Maintenance and Roster Automation available directly in Availity

10.10 Second Opinions

A member, parent, legally appointed representative, or the member's PCP/PCS 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 must be provided at no cost to the member.

The second opinion must be obtained from a network provider (see the Provider Referral Directory). Or, if there is not a network provider with the expertise required for the condition, a non-network provider. Once approved, the PCP/PCS 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/PCS will notify the member of the outcome of the second opinion.

We may also request a second opinion at our own discretion. This may occur under the following circumstances:

- Whenever there is a concern about care expressed by you or the member
- Whenever potential risks or outcomes of recommended or requested care are discovered by the plan during its 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 we request a second opinion, we will make the necessary arrangements for the appointment, payment, and reporting. We will inform the member and the PCP/PCS of the results of the second opinion and the consulting provider's conclusion and recommendation(s) regarding further action.

10.11 Specialty Care Providers

We contract with a network of provider specialty types to meet the medical specialty needs of members and provide all medically necessary covered services. The specialty care provider is a network physician who has the responsibility for providing the specialized care for members, (See [Role and Responsibility of the Specialty Care Provider](#)). In addition to sharing many of the same responsibilities to members as the PCP/PCS (See [Responsibilities of the PCP/PCS](#)), the specialty care provider provides services that include medically necessary covered services as identified in [Section 5](#).

10.12 Role and Responsibility of the Specialty Care Providers

Obligations of the specialists include but are not limited to the following:

- Complying with all applicable statutory and regulatory requirements of the Medicaid program
- Accepting all members referred to them
- Submitting to us required claims information including source of referral and referral number
- Arranging for coverage with network providers while off-duty or on vacation
- Verifying member eligibility and precertification of services (if required) at each visit

- Providing consultation summaries or appropriate periodic progress notes to the member's PCP/PCS on a timely basis, following a referral or routinely scheduled consultative visit
- Notifying the member's PCP/PCS when scheduling a hospital admission or scheduling any procedure requiring the PCP's/PCS approval
- Coordinating care, as appropriate, with other providers involved in providing care for members, especially in cases where there are medical and behavioral health comorbidities or co-occurring mental health and substance abuse disorders

The specialist must:

- Manage the medical and healthcare needs of members, including monitoring and following up on care provided by other providers, including those engaged on a fee-for-service (FFS) basis; provide coordination necessary for referrals to other specialists and FFS providers (both in- and out-of-network); and maintain a medical record of all services rendered by the specialist and other providers.
- Provide 24-hour coverage 7 days a week and maintain regular hours of operation that are clearly defined and communicated to members.
- Provide services ethically and legally in a culturally competent manner that meets the unique needs of members with special healthcare requirements.
- Participate in the systems we established that facilitate the sharing of records, subject to applicable confidentiality and *HIPAA* requirements.
- Participate and cooperate with us in any reasonable internal or external quality assurance, utilization review, continuing education, or other similar programs we established.
- Participate and cooperate in HEDIS and risk adjustment audits conducted by Anthem.
- Make reasonable efforts to communicate, coordinate and collaborate with other specialty care providers, including behavioral health providers, involved in delivering care and services to consumers.
- Participate in and cooperate with our complaint and grievance processes and procedures. We will notify the specialist of any member grievance brought against the specialist.
- Not balance-bill members.
- Continue care in progress during and after termination of their contract for up to 60 days, 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.
- Fill out the maternity risk screen during the first office visit and return it to us via fax at **800-964-3627** in order to identify members who would benefit from OB case management and participate in our New Baby, New LifeSM program.
- Comply with all applicable federal and state laws regarding the confidentiality of patient records.
- Develop and have an exposure control plan regarding blood borne pathogens in compliance with Occupational Safety and Health Administration (OSHA) standards.
- Make best efforts to fulfill the obligations under the Americans with Disabilities Act applicable to their practice location.
- Support, cooperate and comply with our Quality Improvement Program initiatives and any related policies and procedures designed to provide quality care in a cost-effective and reasonable manner.
- Inform us if a member objects for religious reasons to the provision of any counseling, treatment, or referral services.
- Treat all members with respect and dignity; provide members with appropriate privacy; and treat member disclosures and records confidentially, giving the members the opportunity to approve or refuse their release as allowed under applicable laws and regulations.

- Provide to members complete information concerning their diagnosis, evaluation, treatment, and prognosis and give members the opportunity to participate in decisions involving their healthcare, except when contraindicated for medical reasons.
- Advise members about their health status, medical care, or treatment options, regardless of whether benefits for such care are provided under the program; advise members on treatments that may be self-administered.
- When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings.
- Have a policy and procedure to ensure proper identification, handling, transport, treatment, and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.
- Agree to maintain communication with the appropriate agencies such as local police, social services agencies, and poison control centers to provide quality patient care.
- Agree that any notation in a member’s clinical record indicating diagnostic or therapeutic intervention that is part of a clinical research study is clearly distinguished from entries pertaining to non-research-related care.
- Communicate a member’s coordination of care between specialists and PCPs/PCSSs.
- Adhere to the member’s established living will or advance directive on file with the PCP; if the member does not have an advance directive on file with the PCP, the specialist should require the member sign an Advance Directive Acknowledgement form (<http://dhcfnv.gov/Resources/PI/AdvanceDirectives>) and keep it with the member’s medical record.
- Ensure the member’s waiting time is no more than one hour from the scheduled appointment time, except when the provider is unavailable due to an emergency. You are allowed to be delayed in meeting scheduled appointment times when you work in urgent cases, when a serious problem is found or when the patient has an unknown need that requires more services or education than was described at the time the appointment was scheduled.

10.13 Specialty Care Providers Access and Availability

We will maintain a specialty network to ensure access and availability to specialists for all members. A provider is considered a specialist if they have a provider agreement with us to provide specialty services to members. At least once a year, an Anthem vendor will conduct a survey to ensure providers are adhering to Anthem access standards.

Specialists must adhere to the following access guidelines:

Type of care	Standard
Emergent Care	Within 24 hours of referral
Urgent care	Within three calendar days
Routine	Within 30 calendar days
Prenatal care initial visit	First trimester: within seven calendar days of the first request Second trimester: within seven calendar days of the first request Third trimester: within three calendar days of the first request High-risk: within three calendar days of identification of high risk by Anthem or OB provider Immediately: if an emergency exists

Behavioral health providers must adhere to the following access guidelines:

Type of care	Standard
Life Threatening	Immediate access
Care for non-life-threatening emergency	Within six hours
Urgent care	Within 48 hours
Provider referral	Within 24 hours of referral
Routine care	Within 14 business days

10.14 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](https://www.anthem.com/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 and 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 and 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 and develop strategies for communicating to enhance patient understanding.
- **Reducing Health Care 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.

10.15 Member Records

Using nationally recognized standards of care, we work with providers to develop clinical policies and guidelines of care for our membership. The Medical Advisory Committee (MAC) oversees and directs us in formalizing, adopting, and monitoring guidelines. We require medical records to be maintained in a manner that is current, detailed and organized and permits effective and confidential member care and quality review.

You are required to maintain medical records that conform to good professional medical practice and appropriate health management. A permanent medical record will be maintained at the primary care site

for every member and be available to the PCP/PCS and other providers. The member's medical record is the property of the provider who generates the record.

Anthem or the member's previous provider must forward a copy of all medical records in its possession to a new provider within 10 business days from receipt of request.

We will assist the member or the parent/guardian of the member in obtaining a copy of the member's medical record. You must furnish medical records in a timely manner upon receipt of a request, but not more than 30 days from the date of the request. **Providers must supply the first copy of medical records at no charge on request.** The fee for additional copies must not exceed the actual cost of time and materials used to compile, copy, and furnish such records.

Federal regulations (42 CFR 438.240) mandate that each managed care organization have an ongoing quality assessment and performance improvement program for the services it furnishes its members. To comply with this requirement, DHCFP has established 18 quality assurance standards as measurements to assess the effectiveness of the quality program established by each MCO providing medical coverage to Nevada Medicaid and Nevada Check Up. One of these standards includes a comprehensive audit of provider record keeping with specific attention to the member medical record. This section will highlight those elements of the member medical record we will review during our on-site review.

These medical record standards will meet, at a minimum, the following medical record requirements:

1. **Member identification information.** Each page or electronic file in the record must contain the member's name or member ID number.
2. **Personal/demographic data.** The record must include age, gender, address, employer, home, and work telephone numbers and marital status.
3. **Date and corroboration.** All entries must be dated and author identified.
4. **Legibility.** Each record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.
5. **Allergies.** Medication allergies and adverse reactions must be prominently noted on the record. Absence of allergies (no known allergies — NKA) must be noted in an easily recognizable location.
6. **Past medical history.** Past medical history must be easily identified, including serious accidents, operations, and illnesses. For children, the history must include prenatal care of the mother and birth.
7. **Immunizations.** For pediatric members aged 20 and under, a completed immunization record or a notation of prior immunization must be recorded, including vaccines and their dates of administration when possible.
8. **Diagnostic information.**
9. **Medication information** (includes medication information/instruction to member).
10. **Identification of current problems.** Significant illnesses, medical and behavioral health conditions, and health maintenance concerns must be identified in the medical record.
11. **Instructions.** Record must include evidence that the member was provided with basic teaching/instructions regarding physical and/or behavioral health condition.
12. **Smoking/alcohol/substance abuse.** A notation concerning cigarettes and alcohol use and substance abuse must be stated if present for members aged 11 and older and seen three or more times. Abbreviations and symbols may be appropriate.
13. **Consultations, referrals, and specialist reports.** Notes from any referrals and consultations must be in the record. Consultation, lab, and X-ray reports filed in the chart must have the ordering physician's initials or other documentation signifying review. Consultation and any

abnormal lab and imaging study results must have an explicit notation in the record of follow-up plans.

14. **Emergencies.** All emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions while the member is part of the PCP/PCS's panel must be noted.
15. **Hospital discharge summaries.** Discharge summaries must be included as part of the medical record for all hospital admissions that occur while the member is enrolled and for prior admissions, as appropriate. Prior admissions pertaining to admissions that may have occurred prior to the member being enrolled may be pertinent to the member's current medical condition.
16. **Advance directive.** For medical records of members aged 18 and older, the medical record must document whether or not the individual has executed an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney that directs healthcare decision-making for individuals who are incapacitated. A signed Advance Directive Acknowledgement form (<http://dhcfp.nv.gov/Resources/PI/AdvanceDirectives>) should be maintained in the member record.

As part of the medical record review, the nurse reviewer will routinely audit member records for documentation of compliance with Anthem clinical practice guidelines, HEDIS and state mandated EPSDT screening for Medicaid members under age 21. The nurse reviewer will relay their findings to the office at the time of review and identify any deficiencies. If deficiencies are found, a corrective action plan is created and sent to the office, and a reaudit scheduled.

Each year, HEDIS information is collected through claims and encounter data. If claims or encounter data is not available, Quality Management staff will send additional medical record request(s) and/or schedule additional on-site visits in February, March, and April to obtain clinical records for additional data collection.

10.16 Member Visit Data

Documentation of individual encounters must provide adequate evidence of, at a minimum:

1. A history and physical exam that includes appropriate subjective and objective information obtained for the presenting complaints.
2. For members receiving behavioral health treatment, documentation that includes at-risk factors (danger to self or others, ability to care for self, affect, perceptual disorders, cognitive functioning, and significant social health).
3. An admission or initial assessment that must include current support systems or lack of support systems.
4. For members receiving behavioral health treatment, a documented assessment that is done with each visit relating to client status/symptoms to the treatment process and that may indicate initial symptoms of the behavioral health condition as decreased, increased or unchanged during the treatment period.
5. A plan of treatment that includes activities/therapies and goals to be carried out.
6. Diagnostic tests.
7. Documented therapies and other prescribed regimens for members who receive behavioral health treatment and that include evidence of family involvement as applicable and include evidence that the family was included in therapy sessions, when appropriate.
8. Regarding follow-up care encounter forms or notes with a notation indicating follow-up care, a call or a visit that must note in weeks, months, or PRN the specific time to return with unresolved problems from any previous visits being addressed in subsequent visits.

9. Referrals and results including all other aspects of member care, such as ancillary services.

We will systematically review medical records to ensure compliance with the standards. We will institute actions for improvement when standards are not met.

Providers must maintain an appropriate record keeping system for services to our members. This system will collect all pertinent information relating to the medical management of each member and make that information readily available to appropriate health professionals and appropriate state agencies. All records must be retained in accordance with the record retention requirements of 45 CFR 164.316(b) (2), that is, records must be retained for six (6) years from the date of service.

10.17 Clinical Practice Guidelines

Using nationally recognized standards of care, we work with providers to develop clinical policies and guidelines for the care of our membership. We expect you to adhere to the relevant clinical practice guidelines when delivering care to our members. The Medical Advisory Committee (MAC) oversees and directs us in formulating, adopting, and monitoring guidelines.

We select at least four evidence-based clinical practice guidelines that are relevant to the member population. We will measure performance against at least two important aspects of each of the four clinical practice guidelines annually. The guidelines must be reviewed and revised at least every two years or whenever the guidelines change.

A complete list of clinical practice guideline is located on our website. You may request hard copies of them as necessary by contacting Provider Services. See also the **Quality Management** section of this provider manual.

10.18 Advance Directives

We respect the right of the member to control decisions relating to their own medical care, including the decision to have provided, withheld, or withdrawn the medical or surgical means or procedures calculated to prolong their life. 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.

We adhere to The *Member Self-Determination Act* and maintain 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. There are two types of advance directives. A durable power of attorney for healthcare allows the member to name a member advocate to act on behalf of the member. Living wills allow the member to state their wishes about life-sustaining treatment in writing but does not name a member advocate.

Member Services and outreach associates encourage members to request an advance directive form and education from their PCP/PCS at their first appointment.

Members over age 18 and emancipated minors are able to make an advance directive. You should inform members of their right to make an advance directive. The member's response is to be documented in the medical record using a signed Acknowledgment of Member Information on Advance Directives. We will not discriminate or retaliate based on whether a member has or has not executed an advance directive.

While each member has the right without condition to formulate an advance directive within certain limited circumstances, a facility or an individual physician may conscientiously object to an advance directive. If you object to the request for care that is made by an Anthem member in their advance directive, the member may select another PCP or provider who will honor the request. We will assist you and the member in finding another provider.

Member Services and outreach associates will assist members regarding questions about advance directives; however, no associate of ours may serve as witness to an advance directive or as a member's designated agent or representative.

We note the presence of advance directives in the medical records when conducting medical chart audits. Advance directive forms can be found online at <http://dhcftp.nv.gov/Resources/PI/AdvanceDirectives>.

10.19 *Americans with Disabilities Act Requirements*

Our policies and procedures are designed to promote compliance with the *Americans with Disabilities Act of 1990*. You are required to take actions to remove existing barriers and/or to accommodate the needs of members who are qualified individuals with a disability. This action plan includes:

- Street-level access.
- Elevator or accessible ramp into facilities.
- Access to lavatory that accommodates a wheelchair.
- Access to examination room that accommodates a wheelchair.
- Handicap parking clearly marked unless there is street side parking.

11 MEDICAL MANAGEMENT

11.1 Medical Review Criteria

Anthem has its own nationally recognized medical policy process for all of its subsidiary entities. Anthem medical policies, which are publicly accessible on the Anthem *Medical Policy* and *Clinical Utilization Management (UM) Guideline* subsidiary website, are the primary benefit plan policies for determining whether services are considered to be a) investigational/experimental, b) medically necessary, and c) cosmetic or reconstructive.

A list of the specific Anthem Clinical UM Guidelines used is posted and maintained on the provider self-service website and can be obtained in hard copy by written request. The policies described above will support precertification requirements, clinical-appropriateness claims edits and retrospective review.

Written requests can be submitted to:

Provider Services
Desert Canyon Building 9
9133 W. Russell Road
Las Vegas, NV 89148

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. Medical technology is constantly evolving, and we reserve the right to review and periodically update medical policy and utilization management criteria. Except in cases where superseded by Nevada DHCFP or CMS requirements, all nonbehavioral/behavioral health inpatient and outpatient precertification requests and behavioral health concurrent reviews will be determined using Anthem's medical policies and clinical UM guidelines. The MCG Care Guidelines are used for behavioral health and nonbehavioral health concurrent review determinations and/or when the Nevada Medicaid Services Manual and Anthem medical policies are silent. InterQual Care Guidelines are also utilized for neonatal and post-acute non-behavioral health cases. American Society of Addiction Medicine criteria, appropriate to the health need and service provided, will be used when no specific medical policies exist. We work with network providers to develop clinical guidelines of care for our membership. The medical advisory committee (MAC) assists us in formalizing and monitoring guidelines.

The following standards apply to the development of the criteria:

- Criteria are developed with involvement from appropriate providers with current knowledge relevant to the content of treatment guidelines under development.
- Criteria are based on review of market practice and national standards/best practices.
- Criteria are evaluated at least annually by appropriate, actively practicing physicians and other providers with current knowledge relevant to the criteria of treatment guidelines under review and updated, as necessary. The criteria must reflect the names and qualifications of those

involved in the development, the process used in the development, and when and how often the criteria will be evaluated and updated.

Clinical Criteria

We utilize nationally recognized standards of care for clinical decision support for medical management coverage decisions. The criteria provide a system for screening proposed medical care based on member-specific, best medical care practices and rule-based systems to match appropriate services to member needs based upon clinical appropriateness. Criteria include the following:

- Acute care
- Home care
- Radiation therapy
- Rehabilitation
- Subacute care
- Surgery and procedures
- Pharmaceuticals
- Imaging studies and X-rays:
 - Note: Carelon Medical Benefits Management, Inc. manages preauthorization for computerized tomography, computerized axial tomography, nuclear cardiology, magnetic resonance imaging, magnetic resonance angiogram and positron emission tomography scan. They can be contacted at **833-419-2139**.

Our utilization reviewers use these criteria as part of the precertification of scheduled admission, concurrent review, and discharge planning process to determine clinical appropriateness and medical necessity for coverage of continued hospitalization.

Copies of the criteria used in a case to make a clinical determination may be obtained by contacting the local Anthem health plan at **702-228-1308**. You may also submit your request in writing to:

Anthem Blue Cross and Blue Shield Healthcare Solutions
Medical Management
Desert Canyon Building 9
9133 W. Russell Road
Las Vegas, NV 89148

11.2 Utilization Management Decision Making

Anthem, as a corporation and as individuals involved in utilization management (UM) decisions, is governed by the following principles:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Anthem does not reward practitioners or other individuals for issuing denial of coverage or care. Decisions about contracting with or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support 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.

11.3 Precertification/Notification Process

Some procedures require precertification for payment of services. Please check with Provider Services or the website for details.

- Precertification is defined as the prospective process whereby licensed clinical associates apply designated criteria sets against the intensity of services to be rendered, a member's severity of illness, medical history, and previous treatment to determine the medical necessity and appropriateness of a given coverage request.
- Prospective means the coverage request occurred prior to the service being provided.
- Notification is defined as prior to rendering covered medical services to a member, you must notify us by telephone, provider website or fax of the intent to do so. There is no review against medical necessity criteria; however, member eligibility and provider status (network and non-network) are verified.

Preauthorization: The prospective process whereby licensed clinical associates apply designated criteria sets against the intensity of services to be rendered, a member's severity of illness, medical history, and previous treatment to determine the medical necessity and appropriateness of a given coverage request. Prospective means the coverage request occurred prior to the service being provided.

The digital authorization application accessed through Availity is the preferred method for submitting preauthorization requests, offering a streamlined and efficient experience for providers requesting inpatient and outpatient medical or behavioral health services for our members. Additionally, providers can use this application to make inquiries on previously submitted requests, regardless of how they were sent (phone, fax, or another online tool). Capabilities and benefits of the authorization application includes:

- Initiating preauthorization requests online: eliminates the need to fax. The authorization application allows detailed text, photo images and attachments to be submitted along with your request.
- Making inquiries on previously submitted requests via phone, fax, or another online tool.
- Having instant accessibility from almost anywhere, including after business hours.
- Utilizing a dashboard that provides a complete view of all utilization management requests with real-time status updates, including email notifications if requested using a valid email address.
- Viewing real-time results for common procedures with immediate decisions.

You can access the authorization application under Patient Registration > **Authorizations and Referrals** on Availity Essentials. For an optimal experience with the application, use a browser that supports 128-bit encryption. This includes Microsoft Edge, Chrome, Firefox.

11.4 Peer-to-Peer Discussion

If the medical director denies coverage of the request, the appropriate notice of action (including the member's appeal rights) will be mailed to the requesting provider/member's PCP and/or attending physician and member. You have the right to discuss this decision with our medical director within a 30 day time frame from the receipt of the denial by calling the local Anthem plan at **844-396-2330**, Monday through Friday from 8 a.m. to 5 p.m. Pacific time.

12 HOSPITAL AND ELECTIVE ADMISSION MANAGEMENT

12.1 Precertification of All Inpatient Elective Admissions

We require precertification of all inpatient elective admissions. The referring primary care physician, specialist or hospital facility is responsible for precertification.

The referring physician identifies the need to schedule a hospital admission (Physical Health) and must submit the request to our National Contact Center department fax number **800-964-3627**.

Requests for precertification with all supporting documentation should be submitted immediately upon identifying the inpatient request or at least 14 days prior to the scheduled admission. This will allow us to verify benefits and process the precertification request. If a procedure needs to be scheduled prior to the standard 14 days, please contact Anthem directly to notify us. For services that require precertification, we make 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 an authorization is on file by calling our automated Provider Inquiry Line at **844-396-2330** (see [Claim Submission and Adjudication Procedures](#) for instructions on use of the Provider Inquiry Line). If coverage of an admission has not been approved, the facility should call us to speak to a live representative, and we can contact the referring physician directly to resolve the issue. We are available 24 hours a day, 7 days a week to accept precertification requests. When a request for medical services is received from the physician via website, telephone or fax, the care specialist will verify eligibility and benefits. This information will be forwarded to the precertification nurse.

The precertification nurse will review the coverage request and the supporting medical documentation to determine the medical appropriateness of the level of care. When appropriate, the precertification nurse will assist the physician in identifying alternate levels of care 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, an Anthem reference number will be issued to the referring physician. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member's needs and medical history.

If medical necessity criteria for the admission are not met on the initial review, the requesting provider will have the opportunity to discuss the case with our medical director.

If the precertification documentation is incomplete or inadequate, the preauthorization nurse will request the referring provider to submit the additional necessary documentation and refer the case to the medical director.

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

12.2 Emergent Admission Notification Requirements

We prefer immediate notification by network hospitals of emergent admissions. Network hospitals must notify us of emergent admissions within five business days. Our Medical Management staff will verify eligibility and determine benefit coverage, and an Anthem reference number will be issued to the hospital.

We are available 24 hours a day, 7 days a week to accept emergent admission notification (Physical Health) at our National Customer Care department at **844-396-2330** (phone) or **800-964-3627** (fax).

Coverage of emergent admissions is authorized based on review by a concurrent review nurse. When the clinical information received meets nationally recognized standards of care, Anthem will notify the hospital of authorization.

If the notification documentation provided is incomplete or inadequate, we will not approve coverage of the request but will notify the hospital to submit the additional necessary documentation.

If the medical director denies coverage of the request, the attending provider will be afforded the opportunity to discuss the case with our medical director prior to receiving the written determination. The appropriate denial letter will be mailed to the hospital and admitting physician with information about appeal rights and our process.

12.3 Nonemergent Outpatient and Ancillary Services — Precertification and Notification Requirements

We require precertification for coverage of selected nonemergent outpatient and ancillary services (see chart below). To ensure timeliness of the authorization, the expectation of the facility and/or provider is that the appropriate *Precertification Request Form* on <https://providers.anthem.com/nv> is submitted including the following information:

- Member name and ID
- Name, telephone number and fax number of physician performing the elective service
- Name of the facility and telephone number where the service is to be performed
- Date of service
- Member diagnosis
- Name of elective procedure to be performed with CPT-4 code
- Medical information to support requested services (medical information includes current signs/symptoms, past and current treatment plans, response to treatment plans, and medications)

Please visit our provider website for code -specific requirements.

12.4 Precertification/Notification Coverage Guidelines

For services that require precertification, we use nationally recognized standards of care.

We are staffed with clinical professionals who coordinate services provided to members and are available 24 hours a day, 7 days a week to accept precertification requests. When a request for medical

services is received from the physician via website, telephone or fax, the precertification assistant will verify eligibility and benefits, which will then be forwarded to the nurse reviewer.

The nurse will review the request and the supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures. When appropriate, the nurse will assist the physician in identifying alternatives for healthcare delivery as supported by the medical director.

When the clinical information received meets medical necessity criteria, an Anthem reference number will be issued to the referring physician.

If the request is a stat/urgent request (expedited service authorization), the decision will be made within 72 hours.

If the precertification documentation is incomplete or inadequate, the nurse will request additional necessary documentation and may initiate an extension of up to an additional 14 calendar days to obtain required clinical information to render a determination.

If the medical director denies the request for coverage, the attending provider will have the opportunity to discuss the case with our medical director prior to the determination. The appropriate notice of proposed action, along with the member's appeal and state fair hearing rights and process, will be mailed to the requesting provider, the member's primary physician, the facility, and the member.

12.5 Inpatient Reviews

Hospitalists

Anthem contracts with hospitalist groups to manage all adult nonpregnant, nonbehavioral, adult admissions. PCPs may admit and manage their own members. Otherwise, admissions should be directed to the contracted groups. Discharge summaries will be sent from the hospital to your office upon discharge.

Inpatient Admission Reviews

All inpatient hospital admissions, including urgent and emergent admissions, will be reviewed within one business day of the notification of the admission. Our Utilization Review clinician determines the member's medical status through facility medical records, communication with the hospital's Utilization Review department on site review. Appropriateness of stay is documented, and concurrent review is initiated. Cases may be referred to the medical director, who renders a decision regarding the coverage of hospitalization. Diagnoses meeting specific criteria are referred to our care management staff for possible coordination or care management.

Inpatient Concurrent Review

UM clinicians will conduct a concurrent review of the hospital medical record to determine the authorization of coverage for a continued stay.

When the UM clinician reviews the medical records, they also review any discharge planning needs. The UM clinician will conduct continued-stay reviews daily or as often as the clinical situation requires.

We will authorize covered length of stay one day at a time based on the clinical information that supports the continued stay. Exceptions to the one-day length of stay authorization are made for confinements when the severity of the illness and subsequent course of treatment is likely to be several days or is predetermined by state law. Examples of confinement and/or treatment include the following: ICU, CCU, behavioral health rehabilitation and C-section/vaginal deliveries. Exceptions are made by the medical director.

When the clinical information received meets medical necessity criteria, approved days and bed-level coverage will be communicated to the hospital for the continued stay.

If medical necessity criteria are not met for the ongoing inpatient stay, the medical director will give the attending physician the opportunity to discuss the case prior to making a determination. If the decision is to deny the request by the medical director, the appropriate notice of action will be faxed and mailed to the hospital and attending physician, along with the appeal process.

The UM team will coordinate services furnished to the Member, including between settings of care and appropriate discharge planning for short term and long-term hospital and institutional stays. A Member transfer from a facility to an inpatient facility must be completed within twenty-four (24) hours of the facility's determination that the Member is to be discharged to an inpatient facility. The transferring facility should make all attempts to transfer our members to an in-network facility.

12.6 Discharge Planning

Discharge planning is designed to assist you in the coordination of the member discharge when acute care (hospitalization) is no longer necessary.

Our UM clinician will help coordinate discharge planning needs with the hospital utilizations review/care management staff and attending physician. The attending physician is expected to coordinate with the member's PCP/PCS regarding follow-up care after discharge. The PCP/PCS is responsible for contacting the member to schedule all necessary follow-up care. In the case of a behavioral health discharge, the attending physician is responsible for ensuring that the member has secured an appointment for a follow-up visit with a behavioral health provider to occur within seven calendar days of discharge.

When additional/ongoing care is necessary after discharge, we work with you to plan the member's discharge to an appropriate setting for extended services. These services can often be delivered in a nonhospital facility such as skilled nursing facility or in the home with home health.

Discharge plan authorizations follow nationally recognized standards of care. Precertification includes and is not limited to home health, DME, pharmacy, follow-up visits to practitioners or outpatient procedures.

12.7 Confidentiality of Information

Utilization Management, Care Management, Condition Care, discharge planning, quality management and claims payment activities are designed to ensure patient-specific information, particularly protected

health information (PHI) obtained during review, is kept confidential in accordance with applicable laws, including *HIPAA*. Information is used for the purposes defined above. Information is shared only with entities who have the authority to receive such information and only with those individuals who need access to such information to conduct utilization management and related processes.

12.8 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, email, or electronic remittance advice. Providers and facilities are required to immediately destroy misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or redisclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, please call Provider Services at **844-396-2330** for help.

12.9 Emergency Services

The 911 emergency system and 988 behavioral health emergency system should be utilized in the event of an emergency. Emergency services are provided to members without requiring precertification. Any hospital or provider calling for an authorization for emergency services will be granted one immediately upon request. Emergency services coverage includes services that are needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

Emergency medical condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect, in the absence of immediate medical attention, to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergency response is coordinated with community services including the police, fire and EMS departments, juvenile probation, the judicial system, child protective services, chemical dependency, emergency services and local mental health authorities if applicable.

When a member seeks emergency services at a hospital, the determination as to whether the need for those services exists will be made for purposes of treatment by a physician licensed to practice medicine or, to the extent permitted by applicable law by other appropriately licensed personnel under the supervision of, or in collaboration with a physician licensed to practice medicine. The physician or other appropriate personnel will indicate in the member's chart the results of the emergency medical screening examination. We will compensate you for the screenings, evaluations and examinations that are reasonable and calculated to help the healthcare provider determine whether or not the member's condition is an emergency medical condition.

If there is concern surrounding the transfer of a member (for example, the member may not be stable enough for discharge or transfer, or the risks of an unstable transfer may outweigh the medical benefits), the judgment of the attending physician(s) actually caring for the member at the treating facility prevails

and is binding on us. If the emergency department is unable to stabilize and release the member, we will assist in coordination of the inpatient admission regardless of whether the hospital is network or non-network. All transfers from non-network to network facilities are to be conducted only after the member is medically stable and the facility is capable of rendering the required level of care.

If the member is admitted, our concurrent review nurse will implement the concurrent review process to ensure coordination of care. The transferring facility should make all attempts to transfer our members to an in-network facility.

12.10 Urgent Care/After-Hours Care

We require our members to contact their PCP/PCS in situations where urgent, unscheduled care is necessary. If you are unable to see the member, you can refer the member to one of our participating urgent care centers or mobile urgent care providers. If it is during nonbusiness hours, a member can be seen by a provider participating in after-hours care. Precertification with us is not required for a member to access a participating urgent care center or a provider participating in after-hours care. If you are interested in participating in the after-hours care program, please contact Provider Services at **844-396-2330**.

13 QUALITY MANAGEMENT

13.1 Quality Management Program

Overview

We maintain a comprehensive Quality Management program to objectively monitor and systematically evaluate the care and service provided to members. The scope and content of the program reflects the demographic and epidemiological needs of the population served. You and our members have opportunities to make recommendations for areas of improvement. The Quality Management program goals and outcomes are available upon request to members and you by calling the local Quality Management department at **702-228-1308**. Studies are planned across the continuum of care and service, with ongoing proactive evaluation and refinement of the program.

The initial program development was based on a review of the needs of the population served. Systematic re-evaluation of the needs of the health plan's specific population occurs on an annual basis. This includes age/race/gender distribution, and a review of utilization data — inpatient, emergent/urgent care and office visits by type, cost, and volume. This information is used to define areas that are high-volume or that are problem prone.

There is a comprehensive committee structure in place with oversight from our governing body. Not only are the traditional medical advisory committee (MAC) and credentialing committee in place, but a Member Advisory Board (MAB) is also an integral component of the quality management committee structure.

We adopt and disseminate clinical practice guidelines (CPGs) for medical non-preventive, acute and chronic conditions, behavioral health conditions and preventive health conditions. These guidelines are based on current research and national standards. Guidelines are updated at a minimum of every two years or sooner if new information is identified. These guidelines can be downloaded and printed from <https://providers.anthem.com/nv>. You may request a copy of our CPGs by calling Provider Services at **844-396-2330**, Monday through Friday from 8 a.m. to 5 p.m. Pacific time.

HEDIS is one of the most widely used set of healthcare performance measures in the United States. Both Anthem and the Nevada Department of Healthcare Finance and Policy use HEDIS to measure utilization, quality of care and compliance with CPGs. Each year, HEDIS information is collected through claims and encounter data, providers are encouraged to submit Standard Supplemental EMR, Lab and Pharmacy data to report administrative data more accurately. If claims or encounter data is not available, medical practices may be requested to provide clinical records for additional data collection. Chart data collection may be conducted on-site, remote EMR access or via fax beginning in February of each year. HEDIS and state-identified measures are used for provider quality incentive programs.

Provider compliance with CPGs and HEDIS quality measurements is monitored by the Anthem Quality Improvement staff using encounter data, claims and during routine medical record review. The quality staff and medical director is available to provide reports and educational assistance to maximize opportunities for improvement. See [Appendix B](#) for the HEDIS Measures Desktop Reference for Medical Providers.

Quality of Care

All physicians, advanced registered nurse practitioners and physician assistants (PA) are evaluated for compliance with pre-established standards as described in our credentialing program.

Review standards are based on medical community standards, external regulatory and accrediting agencies requirements, and contractual compliance. These reviews are shared with the practitioners to allow them to increase individual and collaborative rates for members.

Reviews are accomplished by Quality Management (QM) coordinators and associate professionals who strive to develop relationships with providers and hospitals that will positively impact the quality of care and services provided to our members. The results are submitted to our QM department and incorporated into a profile.

Our quality program includes review of quality-of-care issues identified for all care settings. QM staff use member complaints, reported adverse events and other information to evaluate the quality of service and care provided to our members.

13.2 Quality Management Committee

The purpose of the quality management committee (QMC) is to maintain quality as a cornerstone of our culture, to be an instrument of change through demonstrable improvement in care and service, to provide a mechanism and forum for interdepartmental participation in the QM program, to integrate and coordinate quality improvement (QI) in care and service throughout Anthem, and to demonstrate quantifiable improvement in care and service.

QMC responsibilities include:

- Establish strategic direction and monitor and support implementation of the QM program.
- Establish processes and structure that ensure NCQA compliance/accreditation.
- Review, monitor and evaluate program compliance against Anthem, state, and federal accreditation standards.
- Review planning, implementation, measurement, and outcomes of clinical/service QI studies.
- Coordinate communication of quality management activities throughout the health plan.
- Review HEDIS data and action plans for improvement.
- Review and approve the annual QM program description.
- Review and approve the annual work plans for each service delivery area.
- Provide oversight, review, and compliance of delegated services.
- Provide oversight and review of subordinate committees.
- Receive and review reports of utilization review decisions and take action when appropriate.
- Analyze member Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and provider satisfaction survey responses and develop action plans for improvement.
- Assure interdepartmental collaboration, coordination, and communication of QI activities.
- Monitor continuity of care between medical and behavioral health services.
- Monitor the plan's operational indicators through the plan's senior staff.
- Monitor accessibility and availability with cultural assessment and competency.
- Make information available about our network hospitals actions to improve safety.

- Make information available about our QI program to members and providers.
- Assure provider involvement through direct input from the medical advisory committee or other mechanisms that allow provider involvement.

Use of Performance Data

Practitioners and providers must allow Anthem to use performance data in cooperation with our quality improvement program and activities.

CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.

13.3 Medical Advisory Committee

The Medical Advisory Committee (MAC) has multiple purposes. The MAC assesses levels and quality of care provided to members and recommends, evaluates, and monitors standards of care. The MAC identifies 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. The MAC oversees the peer review process that provides a systematic approach for the monitoring of quality and the appropriateness of care. The MAC conducts a systematic process for network maintenance through the credentialing/recredentialing process. The MAC advises the health plan administration in any aspect of the health plan policy or operation affecting network providers or members. The MAC approves and provides oversight of the peer review process, the QM program, and the Utilization Review program. It oversees and makes recommendations regarding health promotion activities.

MAC responsibilities include:

- Utilize an ongoing peer review system to monitor practice patterns to assess levels and quality of care and to identify appropriateness of care for improvement/risk prevention activities.
- Approve clinical protocols/guidelines that help ensure the delivery of quality care and appropriate resource utilization.
- Review clinical study design and results.
- Develop action plans/recommendations regarding clinical quality improvement studies.
- Consider/act in response to provider sanctions.
- Provide oversight and approve recommendations of credentialing subcommittee decisions to credential/recredential providers for participation in the plan.
- Approve credentialing/recredentialing policies and procedures; QM policies and procedures, utilization management policies and procedures; disease/case management policies and procedures.
- Oversee member access to care.
- Oversee compliance of delegated services.
- Review and provide feedback regarding new technologies.
- Approve recommendations from subordinate committees.

We welcome your suggestions and invite you to participate in this committee. Please contact your Provider Experience representative or call the health plan at **844-396-2330**.

13.4 Peer Review

The peer review process provides a systematic approach for monitoring the quality and appropriateness of care.

Peer review responsibilities are to:

- Participate in the implementation of the established peer review system.
- Review and make recommendations regarding individual provider peer review cases.
- Work in accordance with the executive medical director.

Should investigation of a member grievance result in concern regarding a physician's compliance with community standards of care or service, all elements of peer review will be followed.

Dissatisfaction severity codes and levels of severity are applied to quality issues. The medical director assigns a level of severity to the grievance. Peer review includes investigation of physician actions by or at the discretion of the medical director. The medical director takes action based on the quality issue and the level of severity, invites the cooperation of the physician, and consults and informs the MAC and peer review committee. The medical director informs the physician of the committee's decision, recommendations, follow-up actions and/or disciplinary actions to be taken. Outcomes are reported to the appropriate internal and external entities, which include the MAC.

The peer review policy is available upon request.

13.5 Member Safety

We believe every member has the right to receive the highest quality of care in every healthcare setting. Improving the safety of healthcare delivery saves lives, reduces costs and increases members' confidence that they are receiving the quality medical care they deserve. It is our intent to work with hospitals and physicians to create a culture of safety in order to minimize the occurrence of events that negatively impact member safety.

We have adopted a provider preventable-conditions-and-never-events policy intended to help keep our members safe. Our provider preventable-conditions-and-never-events policy will be applied to all provider types.

A provider preventable condition is an undesirable or preventable medical condition the member did not have upon entering a healthcare facility but acquired while in the medical custody of the facility. Known risks associated with the procedure are not considered provider preventable conditions.

DHCFP has defined provider preventable conditions to include but not be limited to the following:

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and trauma
- Manifestations of poor glycemic control

- Catheter-associated urinary tract infection
- Catheter-associated vascular infection
- Surgical site infection following coronary artery bypass graft, bariatric surgery, orthopedic procedures
- Deep vein thrombosis/pulmonary embolism associated with total knee replacement or hip replacement surgery, other than in pediatric and/or obstetric members
- Surgery or other invasive procedure performed on the wrong body part
- Surgery or other invasive procedure performed on the wrong member
- Wrong surgical procedure performed on the member

Never events are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for members. These errors should never occur in healthcare. These errors may occur in inpatient settings as well as other settings, including but not limited to outpatient hospital settings, nursing facility settings or ambulatory care settings.

Anthem defines never events as:

- The surgery or other invasive procedure is performed on the wrong body part.
- The surgery or other invasive procedure is performed on the wrong member.
- The wrong surgical/invasive procedure is performed on the member.

You are expected to furnish us with information about conditions that are present on admission (POA) using POA indicators. POA indicators will not negatively impact provider reimbursement.

You will also be expected to self-report incidents of provider preventable conditions and never events. We will closely review admissions with potential provider preventable conditions or never events through claims review, medical director review of cases, concurrent review, member complaints, outpatient prior authorizations, case management sources, etc. Once a potential provider preventable condition or never event is identified, the case will be investigated to the extent necessary to verify whether a provider preventable condition or never event has occurred.

We will not reimburse providers for additional inpatient days at a facility or subsequent outpatient services that directly and exclusively result from a provider preventable condition. We also will not reimburse providers for inpatient or outpatient care as a direct result of a never event. If, as a direct result of the provider preventable condition or never event, the member requires services that are in addition to other medically necessary services at the appropriate level of care, payment to providers will be reduced to exclude the costs of the additional services. Payment reductions and denials will be limited to the added cost of the member care directly resulting from the provider preventable condition or never event.

If a provider preventable condition or never event is caused by one provider or facility (primary provider) and is then treated at a different facility or provider (secondary provider), payment will not be denied to the secondary provider. We will make appropriate payments to the secondary provider and pursue recovery of all money in full, including but not limited to legal expenses and other recovery costs from the primary provider. This recoupment may be recovered directly from the primary provider or through subrogation of the injured member's settlement. The anticipated costs of long-term healthcare

consequences to the member that are directly related to the provider preventable condition or never event will also be considered in all recoveries.

We will report such incidents to the Nevada DHCFP as required or upon request.

13.6 Critical Incident Reporting

Anthem has developed and implemented a Critical Incident (CI) Reporting and Management system. Critical Incidents include Sentinel Events, Quality of Care Concerns, and other Critical Incidents members may experience while in nursing facilities, inpatient behavioral health treatment, adult day care centers, member home or any other community-based setting. Anthem regularly reviews the number and type of incidents across settings and findings from investigations. The maximum time period for reporting an incident to Anthem is twenty-four (24) hours.

Identification

Critical Incidents may be identified in a variety of ways including both internal and external sources.

External Sources:

- Department of Health and Human Services
- State Department of Health
- State Medicaid Agency
- Centers for Medicare and Medicaid Services (CMS)
- Member or authorized representative
- Providers

Internal Sources:

- Behavioral Health
- Claims Review
- Case Management
- Member Complaints and Grievances
- National Customer Care (NCC)
- Provider Relations Account Management

Reportable Critical Incidents

Individual Critical Incident reports are submitted for the following:

- A major injury or major trauma that has the potential to cause prolonged disability or death of a member that occurs in a facility licensed by the State to provide publicly funded Behavioral Health Services.
- An unexpected death of a member that occurs in a facility licensed by the State to provide publicly funded Behavioral Health Services.
- Abuse, neglect, or exploitation or unexpected death of a member (not to include child abuse).
- Unauthorized leave of a mentally ill offender or a sexual or violent offender from a mental health facility, secure Community Transition Facilities (i.e., Evaluation and Treatment Centers, Crisis Stabilization Units, Secure Detox Units, and Triage Facilities) that accept involuntary admissions.

- Any event involving a member that has attracted or is likely to attract media attention.

Critical Incidents are reported by Anthem within one (1) Business Day in which Anthem becomes aware of the event. The report shall include:

- The date Anthem became aware of the incident.
- The date of the incident.
- A description of the incident.
- The name of the facility where the incident occurred, or a description of the incident location.
- The name(s) and age(s) of Member(s) involved in the incident.
- The name(s) and title(s) of facility personnel or other staff involved.
- The name(s) and relationship(s), if known, of other persons involved and the nature and degree of their involvement.
- Member whereabouts at the time of the report if known (i.e., home, jail, hospital, unknown, etc.) or actions taken by Anthem to locate the member.
- Actions planned or taken by Anthem to minimize harm resulting from the incident.
- Any legally required notifications made by the Contractor.

Individual Critical Incident Resolution and Closure

Anthem will submit follow-up reports using the Incident Reporting System and close the case within 45 calendar days after the critical incident was initially reported. A case cannot be closed until the following information is provided:

- A summary of any debriefings.
- Whether the member is in custody (jail), in the hospital or in the community.
- Whether the member is receiving services and include the types of services provided.
- If the member cannot be located, the steps Anthem has taken to locate the Member using available, local resources.
- In the case of the death of a member, verification from official sources that includes the date, name, and title of the sources. When official verification cannot be made, Anthem shall document all attempts to retrieve it.

Reporting Periods

Anthem Nevada providers are required per state guidelines to report a Critical Incident to Anthem Quality Department within 24 hours.

Provider Reporting Channel

Providers must notify Anthem of any critical incident either online or via telephone.

- Provider Services at **844-396-2330**

Email Critical Incident reports to nevadacireports@anthem.com

14 CREDENTIALING

To participate in the Medicaid managed care program, a provider must have applied for enrollment in the Nevada Medicaid program and be a licensed provider by the state before signing a contract with us.

All providers are required to have a State Medicaid ID that is active in order to be a contracted provider in our Anthem Medicaid Network. Anthem providers may execute Network Provider contracts, pending the outcome of the screening, enrollment, and revalidation process of up to one hundred twenty (120) Calendar Days but Anthem must terminate a Network Provider immediately upon notification from the State that the Network Provider cannot be enrolled, or the expiration of one hundred twenty (120) day period without Medicaid enrollment of the Provider, and notify affected Members.

Once terminated by Anthem, should a provider's State Medicaid ID be reinstated or the provider is re-enrolled, the provider will need to successfully complete Anthem's credentialing process to become a Participating Provider.

Our credentialing policies and procedures incorporate the current NCQA Standards and Guidelines for the Accreditation of MCOs as well as DHCFP requirements for the credentialing and recredentialing of licensed independent providers and organizational providers with whom it contracts.

Each provider agrees to submit for verification all requested information necessary to credential or recredential physicians providing services in accordance with the standards we have established. Each provider will cooperate with us as necessary to conduct credentialing and recredentialing pursuant to our policies, procedures, and rules.

14.1 Credentialing Requirements

Each provider, applicable ancillary/facility and hospital will remain in full compliance with our credentialing criteria as set forth in its credentialing policies and procedures and all applicable laws and regulations. Each practitioner will complete the Nevada Uniform Credentialing Form NDOI-901, which is located at http://doi.nv.gov/uploadedFiles/doingov/_public-documents/Insurers/Uniform%20Credentialing.pdf, and the organizational providers (for example, ancillary/facility and hospital) will complete our application form upon request. Each provider will comply with other such credentialing criteria as we may establish.

14.2 Credentialing Procedures

We are committed to operating an effective, high-quality credentialing program. We credential the following provider types: medical doctors, doctors of osteopathy, doctors of dental surgery, doctors of dental medicine, doctors of podiatric medicine, doctors of chiropractic, physician assistants, optometrists, dentists, nurse practitioners, certified nurse midwives, licensed professional counselors/social workers, psychologists, physical/occupational therapists, speech/language therapists and other applicable or appropriate mid-level providers, as well as hospitals and allied services (ancillary) providers.

During recredentialing, you must show evidence of satisfying these policy requirements and must have satisfactory results relative to our measures of quality of healthcare and service.

We have established a credentialing committee and a medical advisory committee (MAC) for the formal determination of recommendations regarding credentialing decisions. The credentialing committee makes decisions regarding participation of initial members and their continued participation at the time of recredentialing. The oversight rests with the MAC.

Our credentialing policy is revised periodically based on input from several sources, including but not limited to the credentialing committees, the health plan medical director, our chief medical officer, and state and federal requirements. The policy will be reviewed and approved as needed but at a minimum annually.

The provider application contains your actual signature that serves as an attestation of the credentials summarized on and included with the application. Your signature also serves as a release of information to verify credentials externally. We are responsible for externally verifying specific items attested to on the application. Any discrepancies between information included with the application and information obtained by us during the external verification process will be investigated and documented and may be grounds for refusal of acceptance into the network or termination of an existing provider relationship. The signed agreement documents compliance with our managed care policies and procedures.

You have the right to inquire about the status of your application. You may do so by the following methods:

1. Telephone
2. Facsimile
3. Contacting the Credentialing department directly via email at NVCredentialing@anthem.com
4. In writing

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.

As an applicant for participation with Anthem, each provider has the right to review information obtained from primary verification sources during the credentialing process to the extent that is not a violation of state or federal regulations. Upon notification from us, you have the right to explain information obtained that may vary substantially from that provided and to provide corrections to any erroneous information submitted by another party. You will be contacted within 30 calendar days of the identification of the issue. The notification will also include the specific process for submission (a written explanation or appearance before the credentialing committee if deemed necessary) of this additional information, including where it should be sent. You will be given no less than 14 calendar days to provide additional information.

Currently, the following verifications are completed, as applicable, prior to final submission of a practitioner file to the health plan medical director or credentialing committee. To the extent allowed under applicable law or state agency requirements, per NCQA Standards and Guidelines, the medical director has authority to approve clean files without input from the credentialing committee. All files not

designated as a clean file will be presented to the credentialing committee for review and decision regarding participation.

In addition to the submission of an application and the execution of a Participating Provider Agreement, the following must be reviewed and approved by the credentialing committee or the medical director.

1. **Board Certification.** Verification by referencing the American Medical Association (AMA) Provider Profile, American Osteopathic Association (AOA), the American Board of Medical Specialties (ABMS), American Board of Podiatric Surgery (ABPS), and/or American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM).
2. **Verification of Education and Training.** Verification by referencing board certification, the American Medical Association (AMA) Provider Profile, the appropriate state-licensing agency, or the educational institution.
3. **Verification of Work History.** The practitioner must submit a curriculum vitae documenting work history for the past five years. Any gaps in work history greater than six months must be explained in written format and brought to the attention of the medical director and credentialing committee as applicable.
4. **Hospital Affiliations and Privileges.** To the extent allowed under applicable law or state agency requirements, verification of clinical privileges in good standing at an Anthem network hospital may be accomplished by the use of an attestation signed by you. If attestation is not acceptable, hospital admitting privileges in good standing are verified for the practitioner. This information is obtained in the form of a written letter from the hospital, roster format (multiple practitioners), internet access or by telephone contact. The date and name of the person spoken to at the hospital are documented.
5. **State Licensure or Certification.** Verification of state license information to ensure that the practitioner maintains a current legal license or certification to practice in the state. This information can be verified by referencing data provided to us by the state via roster, telephone, written verification or through the internet.
6. **DEA Number.** Verification of the Drug Enforcement Administration (DEA) number to ensure that the practitioner is currently eligible to prescribe controlled substances. This information is verified by obtaining a copy of the DEA certificate or by referencing the National Technical Information Service (NTIS) data. If the practitioner is not required to possess a DEA certificate but does hold a state-controlled substance certificate, the Controlled Dangerous Substance (CDS) certificate is verified to ensure the practitioner is currently eligible to prescribe controlled substances. This information is verified by obtaining a copy of the CDS certificate or by referencing CDS online or internet data if applicable.
7. **Professional Liability Coverage.** To the extent allowed under applicable law or state agency requirements, verification of malpractice coverage may be accomplished by the use of an attestation signed by the provider indicating the name of the carrier, policy number, coverage limits and the effective and expiration dates of such malpractice coverage. If attestation is not acceptable, the practitioner's malpractice insurance information is verified by obtaining a copy of the professional liability insurance face sheet from the practitioner or from the malpractice insurance carrier. Practitioners are required to maintain professional liability insurance in specified amounts.
8. **Professional Liability Claims History.** Verification of an applicant's history of professional liability claims, if any, is reviewed by the health plan's credentialing committee to determine whether acceptable risk exposure exists. The review is based on information provided and

attested to by the applicant and information available from the National Practitioner's Data Bank (NPDB). The credentialing committee's policy is designed to give careful consideration to the medical facts of the specific cases, total number, and frequency of claims in the past five years, and the amounts of settlements and/or judgments.

9. ***CMS Sanctions.*** Verification that the practitioner's record is clear of any sanctions by Medicare/Medicaid. This information is verified by accessing the NPDB.
10. ***Disclosures — Attestation and Release of Information.*** Our Provider Application will require responses to the following:
 - Reasons for the inability to perform the essential functions of the position with or without accommodation
 - Any history or current problems with chemical dependency, alcohol, or substance abuse
 - History of license revocations, suspension, voluntary relinquishment, probationary status or other licensure conditions or limitations
 - History of conviction of any criminal offense other than minor traffic violations
 - History of loss or limitation of privileges or disciplinary activity, including denial, suspension, limitation, termination or nonrenewal of professional privileges
 - History of complaints or adverse action reports filed with a local, state, or national professional society or licensing board
 - History of refusal or cancellation of professional liability insurance
 - History of suspension or revocation of a DEA or CDS certificate
 - History of any Medicare/Medicaid sanctions
 - Attestation by the applicant of the correctness and completeness of the applicationAny issue identified must be explained in writing. These explanations are presented with your application to the credentialing committee.
11. The NPDB is queried against members and our contracted providers. The NPDB will provide a report for every practitioner queried. These reports are shared with the medical director and the credentialing committee for review and action as appropriate. The appropriate state-licensing board/agency is queried to verify any restrictions/sanctions made against the practitioner's license. All sanctions are investigated and documented, including the health plan's decision to accept or deny the applicant's participation in the network.
12. ***Recredentialing.*** At the time of recredentialing (every three years), information for PCPs/PCSs from quality improvement activities and member complaints is presented for credentialing committee review.

You will be notified by telephone or in writing if any information obtained in support of the assessment or reassessment process varies substantially from the information submitted by the providers. You have the right to review the information submitted in support of the credentialing and recredentialing process and to correct any errors in the documentation. This will be accomplished by submission of a written explanation or by appearance before the credentialing committee if so requested.

The decision to approve or deny initial participation will be communicated in writing within 60 days of the credentialing committee's decision. To the extent allowed under applicable law or state agency requirements per NCQA Standards and Guidelines, the medical director may render a decision regarding the approval of clean files without benefit of input from the credentialing committee. In the event your continued participation is denied, you will be notified by certified mail. If continued participation is denied, you will be allowed 30 days to appeal the decision.

Credentialing — Organizational Providers

The provider application contains your actual signature that serves as an attestation that the healthcare facility agrees to the assessment requirements. Providers requiring assessments are as follows: hospitals, home health agencies, skilled nursing facilities, nursing homes, ambulatory surgical centers and behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting. Your signature also serves as a release of information to verify credentials externally.

Currently, the following steps are completed in addition to the application and Network Provider Agreement before approval for participation of a hospital or organizational provider.

State licensure is verified by obtaining a current copy of the state license from the organization or by contacting the state-licensing agency. Primary source verification is not required. Any restrictions to a license are investigated and documented, including the decision to accept or deny the organization's participation in the network.

We contract with facilities that meet the requirements of an unbiased and recognized authority. Hospitals (acute, transitional or rehabilitation) should be accredited by The Joint Commission (TJC), Health Care Facilities Accreditation Program or the AOA. The Commission on Accreditation of Rehabilitation Facilities may accredit rehabilitation facilities. Home health agencies should be accredited by TJC or the Community Health Accreditation Program. Nursing homes should be accredited by TJC. TJC or the Accreditation Association for Ambulatory Health Care should accredit ambulatory surgical centers. If facilities, ancillaries, or hospitals are not accredited, we will accept a copy of a recent state or CMS review in lieu of performing an on-site review. If accreditation or copy of a recent review is unavailable, an on-site review will be performed.

- A copy of the malpractice insurance face sheet is required. Organizations are required to maintain malpractice insurance in the amounts specified in the provider contract and according to Anthem policy.
- We will track a facility's/ancillary's reassessment date and reassess every 36 months as applicable. Requirements for recredentialing of organizational providers are the same for reassessment as they are for the initial assessment.

The organization will be notified either by telephone or in writing if any information obtained in support of the assessment or reassessment process varies substantially from the information submitted by the organization.

Organizations have the right to review the information submitted in support of the assessment process and to correct any errors in the documentation. This will be accomplished by submission of a written explanation or by appearance before the credentialing committee if so requested.

The decision to terminate an organization's participation will be communicated in writing via certified mail.

Peer Review

The peer review process provides a systematic approach for monitoring the quality and appropriateness of care.

Peer review responsibilities are to:

- Participate in the implementation of the established peer review system.
- Review and make recommendations regarding individual provider peer review cases.
- Work in accordance with the executive medical director.

Should investigation of a member grievance result in concern regarding a physician's compliance with community standards of care or service, all elements of peer review will be followed.

Dissatisfaction severity codes and levels of severity are applied to quality issues. The medical director assigns a level of severity to the grievance. Peer review includes investigation of physician actions by or at the discretion of the medical director. The medical director takes action based on the quality issue and the level of severity, invites the cooperation of the physician, and consults and informs the MAC and peer review committee. The medical director informs the physician of the committee's decision, recommendations, follow-up actions and/or disciplinary actions to be taken. Outcomes are reported to the appropriate internal and external entities, which include the MAC.

The peer review policy is available upon request.

Member Safety

We believe every member has the right to receive the highest quality of care in every healthcare setting. Improving the safety of healthcare delivery saves lives, reduces costs and increases members' confidence that they are receiving the quality medical care they deserve. It is our intent to work with hospitals and physicians to create a culture of safety in order to minimize the occurrence of events that negatively impact member safety.

We have adopted a provider preventable-conditions-and-never-events policy intended to help keep our members safe. Our provider preventable-conditions-and-never-events policy will be applied to all provider types.

A provider preventable condition is an undesirable or preventable medical condition the member did not have upon entering a healthcare facility but acquired while in the medical custody of the facility. Known risks associated with the procedure are not considered provider preventable conditions.

DHCFP has defined provider preventable conditions to include but not be limited to the following:

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and trauma
- Manifestations of poor glycemic control
- Catheter-associated urinary tract infection
- Catheter-associated vascular infection

- Surgical site infection following coronary artery bypass graft, bariatric surgery, orthopedic procedures
- Deep vein thrombosis/pulmonary embolism associated with total knee replacement or hip replacement surgery, other than in pediatric and/or obstetric members
- Surgery or other invasive procedure performed on the wrong body part
- Surgery or other invasive procedure performed on the wrong member
- Wrong surgical procedure performed on the member

Never events are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for members. These errors should never occur in healthcare. These errors may occur in inpatient settings as well as other settings, including but not limited to outpatient hospital settings, nursing facility settings or ambulatory care settings.

Anthem defines never events as:

- The surgery or other invasive procedure is performed on the wrong body part.
- The surgery or other invasive procedure is performed on the wrong member.
- The wrong surgical/invasive procedure is performed on the member.

You are expected to furnish us with information about conditions that are present on admission (POA) using POA indicators. POA indicators will not negatively impact provider reimbursement.

You will also be expected to self-report incidents of provider preventable conditions and never events. We will closely review admissions with potential provider preventable conditions or never events through claims review, medical director review of cases, concurrent review, member complaints, outpatient prior authorizations, case management sources, etc. Once a potential provider preventable condition or never event is identified, the case will be investigated to the extent necessary to verify whether a provider preventable condition or never event has occurred.

We will not reimburse providers for additional inpatient days at a facility or subsequent outpatient services that directly and exclusively result from a provider preventable condition. We also will not reimburse providers for inpatient or outpatient care as a direct result of a never event. If, as a direct result of the provider preventable condition or never event, the member requires services that are in addition to other medically necessary services at the appropriate level of care, payment to providers will be reduced to exclude the costs of the additional services. Payment reductions and denials will be limited to the added cost of the member care directly resulting from the provider preventable condition or never event.

If a provider preventable condition or never event is caused by one provider or facility (primary provider) and is then treated at a different facility or provider (secondary provider), payment will not be denied to the secondary provider. We will make appropriate payments to the secondary provider and pursue recovery of all money in full, including but not limited to legal expenses and other recovery costs from the primary provider. This recoupment may be recovered directly from the primary provider or through subrogation of the injured member's settlement. The anticipated costs of long-term healthcare consequences to the member that are directly related to the provider preventable condition or never event will also be considered in all recoveries.

We will report such incidents to the Nevada DHCFP as required or upon request.

15 PROVIDER DISPUTE PROCEDURES

15.1 Provider Administrative Denial

An administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions or lack of precertification.

15.2 Provider Administrative Appeal Procedure

If you are dissatisfied with an administrative denial, you may file an administrative appeal by submitting a written request with supporting documentation as to why the administrative requirements were met. A form to file an appeal can be found on the provider website.

An administrative appeal must be filed within 60 calendar days from the date on the administrative denial notice.

Administrative appeals can be submitted through Availity at <http://www.availity.com>

The administrative appeals can be mailed to the following address:

Anthem Blue Cross and Blue Shield Healthcare Solutions
Appeals Department
P.O. Box 62429
Virginia Beach, VA 23466-2429
FAX: 888-235-9334

You may file a verbal and/or written administrative appeal.

If the verbal and/or written request is not received within the specified time frame, the administrative appeal will be closed, and no review will take place. A letter will be mailed to you explaining that your required written follow-up was not received, and your administrative appeals has been closed. The letter will further explain that if your verbal and/or written request is received prior to the timely filing limit, a review will take place, but it will be considered a new request. The new receipt date will be used for calculating the required 30-calendar day turnaround time for determination.

We will render a decision and send a determination letter within 30 calendar days of receiving the administrative appeal. If we uphold our original decision, we will mail you a letter. This letter will include information about your rights to request a State Fair Hearing from the state within 120 calendar days of the date on the final determination letter. If we overturn our decision, the claim will be reprocessed, or you will be notified of the action that needs to be taken.

You will not be penalized for filing an administrative appeal.

15.3 Provider Grievance (Complaint) Procedures

Anthem maintains a system for the resolution of provider grievances including a process for the notice and appeal of any dissatisfaction expressed by a provider verbally or in writing to Anthem. Provider grievances will be resolved in a fair and timely manner.

Grievance: An expression of dissatisfaction about any matter or aspect of the health plan or its operations that is not included in medically necessary denials.

Provider: Any physician, hospital, facility, or other healthcare professional who is licensed or otherwise authorized to provide healthcare services in the state or jurisdiction in which they are furnished.

You can file a grievance (complaint) at any time in writing via letter or fax to:

Anthem Blue Cross and Blue Shield Healthcare Solutions
Provider Grievance Department
9133 W. Russell Road
Las Vegas, NV 89148
Fax: **866-495-8711**

Anthem ensures that punitive or retaliatory action is not taken against a provider who files a grievance or against a provider who supports a member's grievance.

Anthem National Customer Care representatives are available to receive inquiries over the phone. The representatives will attempt to resolve all inquiries at the time of the initial call. If they cannot resolve an inquiry to a provider's satisfaction, they refer the inquiry to the appropriate area for resolution.

Anthem will thoroughly investigate each provider grievance using applicable statutory, regulatory, contract provisions, collecting all pertinent facts from all parties and applying the health plan's written policies and procedures.

The investigation and final resolution for each grievance will be completed within 90 calendar days of the date of receipt.

A grievance resolution letter is sent to the provider that contains, at a minimum, the following:

- All information considered in investigating the grievance
- Findings and conclusions based on the investigation
- The disposition of the grievance

15.4 Provider Payment Disputes

Claims Payment Inquiries or Appeals

Our Provider Experience program helps you with claims payment and issue resolution. Just call **844-396-2330**, select the Claims prompt, and we will connect you with a dedicated resource team called the Provider Service Unit (PSU) to ensure:

- Availability of helpful, knowledgeable representatives to assist you.

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

Use the secure Provider Availity Payment Appeal Tool at <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.

Claims Correspondence vs. Payment Appeal

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

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?
Electronic Data Interchange (EDI) Rejected claim(s)	Contact Availity Client Services at 800-Availity (282-4548) or your clearinghouse vendor when your claim was submitted electronically but was never paid or was rejected. Availity is available to assist you with setup questions and help resolve submission issues or electronic claims rejections. Rejected claims will return on the EDI response reports, if you use a clearinghouse vendor, they are responsible for delivering to your organization.
EOP requests for supporting documentation (sterilization/hysterectomy/abortion consent forms, itemized bills, and invoices)	Submit a Claim Correspondence form, a copy of your EOP and the supporting documentation to: Anthem Blue Cross and Blue Shield Healthcare Solutions Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
EOP requests for medical records	Submit a Claim Correspondence form, a copy of your EOP and the medical records to: Anthem Blue Cross and Blue Shield Healthcare Solutions Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
Need to submit a corrected claim due to errors or changes on original submission	Submit a Claim Correspondence form and your corrected claim to: Anthem Blue Cross and Blue Shield Healthcare Solutions Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599 Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return

Type of Issue	What Do I Need to Do?
	<p>claims that have been altered with an explanation of the reason for the return.</p> <p>For corrected professional electronic claims submitted via EDI claim professional, providers should use one the following frequency codes to indicate a correction was made to a previously submitted and adjudicated claim: 7 – Replacement of Prior Claim 8 – Void/Cancel Prior Claim</p> <p>For corrected institutional electronic claims submitted via EDI, providers should use one the following Bill Type Frequency Codes to indicate a correction was made to a previously submitted and adjudicated claim: 0XX7 – Replacement of Prior Claim 0XX8 – Void/Cancel Prior Claim</p> <p>Use Availity Essentials to submit a single claim submission using the 7 as the frequency type code and original claim number.</p>
Submission of coordination of benefits/third-party liability information	<p>Submit a Claim Correspondence form, a copy of your EOP and the COB/TPL information to: Anthem Blue Cross and Blue Shield Healthcare Solutions Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599</p>
Emergency room payment review	<p>Submit a Claim Correspondence form, a copy of your EOP and the medical records to: Anthem Blue Cross and Blue Shield Healthcare Solutions Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599</p>

Payment Appeals

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

- Contractual payment issues.
- Inappropriate or unapproved referrals initiated by providers.
- 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.

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

Our procedure is designed to afford providers access to a timely payment appeal process. We have a two-level appeal process for provider to dispute claim payments. If a provider is dissatisfied with the resolution of a first-level appeal, we afford the provider the option to file a second-level appeal.

If you disagree with a previously processed claim or adjustment, you may submit to us a verbal or written request for reconsideration.

The payment appeal for reconsideration, whether verbal or written, must be received by Anthem within 60 calendar days of the Explanation of Payment (EOP) paid date or recoupment date.

In a situation where a problem has been identified that affects multiple claims and/or multiple providers or in a situation where we have identified an issue that has caused multiple underpayments, we will consider claims for reprocessing with dates of service 90 days prior to the received date of the original provider payment dispute for network providers. After this time period has lapsed, underpaid claim adjustments will be made on an exception basis.

Due to the nature of appeals, some cannot be accepted verbally and therefore must be submitted in writing. The following table provides guidance for determining the appropriate submission method.

Issue Type	Verbal Allowed?
Denied for timely filing	If Anthem made an error per your contract, verbal is allowed.
Denied for no authorization	<ul style="list-style-type: none"> • If you know an authorization was provided and Anthem made an error, verbal is allowed. • If you have paper proof, written is required.
Retrospective authorization issue	If requesting retro review, written is allowed.
Denied for need of additional medical records (<i>Denials issued for this reason are considered nonclean claims and will not be logged as appeals. These will be treated as inquiries/correspondence.</i>)	<ul style="list-style-type: none"> • Written is required if records have not been received previous to call. • If records were previously sent and you know they were received and on file, verbal is allowed.
You feel you were not paid according to your contract	Verbal is allowed.
The member does not have other health insurance, but the claim was denied for other health insurance	Verbal is allowed.
Claim code-editing denial	Written is required.
Denied as duplicate	Verbal is allowed.
Claim denied related to provider data issue	Verbal is allowed.
Retro-eligibility issue	Verbal is allowed.
Experimental procedure denial	Written is required.
Claims data entry error: data elements on the claim on file does not match the claim you submitted	Verbal is allowed.

Issue Type	Verbal Allowed?
Second-level appeal	Must be provided in writing; verbal is not accepted.

If after reviewing this table you determine a verbal appeal is allowed, call the Provider Service Unit (PSU) at **844-396-2330**.

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

Anthem Blue Cross and Blue Shield Healthcare Solutions
 Payment Appeals
 P.O. Box 61599
 Virginia Beach, Virginia 23466-1599

Written appeals with supporting documentation can also be submitted via the Appeal tool using Availity Essentials. Use **Claim Status** located under the **Claims & Payment** menu, if a claim is considered appealable due to no or partial payment, a dispute selection box may display. Once this box is selected a web form will display for you to complete and submit. Navigate to the **Claims & Payment** menu and select **Appeals**, locate your initiated request, and complete it by adding your documentation. If all required fields are completed, you will receive immediate acknowledgement of your submission.

When submitting the appeal verbally or in writing you need to provide:

- A listing of disputed claims.
- A detailed explanation of the reason for the appeal.
- Supporting statements for verbal appeals and supporting documentation for written; written appeals should also include a copy of the EOP and an *Appeal Request* form.

Verbal appeals received by the PSU are logged into the appeal database. Written payment appeals are received in our Document Management Department (DMD) and date-stamped upon receipt. The DMD scans the appeal into our 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 associates work appeals by demand, drawing items based on 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.
- Contact you via your 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. Your preferred method of communication is determined from the PSU agent requesting this information during your call or your selection on the Appeal Request form. If no preference is provided, a letter will be mailed to you.

If your claim(s) remains denied or partially paid or you continue to disagree, you may file a second level appeal in writing. Second-level verbal appeals will not be accepted. The second-level appeal must be received by Anthem within 30 calendar days from the date of the first-level decision/resolution letter. Second-level appeals received after this will be upheld for untimely filing and will not be considered for further payment. You must submit a written second-level dispute to the centralized address for disputes. A more senior appeal associate, or one that did not complete the first-level review, will conduct the second-level review.

If additional information is submitted to support payment, the denial is overturned. Otherwise, the appeal associate conducts the review as per the steps in the first-level process.

Once the dispute is reviewed for the second level, the appeal associate will notify you of the decision via your preferred method of communication within 30 calendar days of receipt of the second-level payment appeal.

A licensed/registered nurse will review payment appeals received with supporting clinical documentation when medical necessity review is required. We will apply established clinical criteria to the payment appeal. After review, we will either approve the payment dispute or forward it to the medical director for further review and resolution.

15.5 Provider State Fair Hearing Process

As an Anthem participating provider, you have the right to submit a written request for a State Fair Hearing from the DHCFP when you have exhausted our internal dispute (appeal) system without receiving a wholly favorable resolution decision.

You may request a State Fair Hearing after exhausting our appeals process in the following situations only:

- Reduction, suspension, or termination of a previously authorized service
- Denial of limited authorization of a previously authorized service
- The denial for disenrollment for good cause
- Denial, in whole or in part, of payment for a service
- Demand for recoupment
- Failure of Anthem to meet specified time frames (for example, authorization, claims processing, appeal resolution)

The request for a State Fair Hearing must be submitted in writing within 90-calendar days from the date of our denial notice letter. You may ask for a State Fair Hearing from DHCFP by completing the Provider State Fair Hearing form and sending it with our notice of decision to:

Nevada Division of Health Care Financing and Policy
Hearings Unit
1100 E. William St., Suite 102
Carson City, NV 89701
Hearings Unit: **775-684-3604**

In addition to the signed Provider State Fair Hearing form and our *Notice of Decision* letter, please supply the following required documentation:

- A copy of the Anthem *Notice of Adverse Benefit Determination* letter.
- A copy of the Remittance Advice page(s) showing the denial
- A copy of the original signed claim or service requested
- Any documentation to support the issue (for example, prior authorization, physician's notes, ER reports)

After you ask for a fair hearing by submitting the Provider State Fair Hearing form and all required documentation to the DHCFP hearings supervisor, you will receive a letter telling you the date and time of the scheduled hearing preparation meeting (HPM). The HPM will be held at the earliest possible date after DHCFP receives your fair hearing request and all required documentation. The HPM will be held by phone and is scheduled in an attempt to resolve your dispute prior to conducting the formal fair hearing. If after the HPM your dispute is not resolved, a formal fair hearing with the Department of Administration Appeals Office will be scheduled.

You may represent yourself or be represented at the fair hearing by legal counsel or your authorized designate. **You, your legal representative or your authorized designate must be present at the formal fair hearing.** You must sign the Provider State Fair Hearing form where required, and it must be furnished to the Medicaid office along with all required documentation prior to the hearing.

After the State Fair Hearing, you, and your legal representative or authorized designate will be notified by certified mail of the hearing officer's decision. The decision of the hearing officer is final. For more information, the fair hearing process for providers is cited at NRS §422.306 and is described in the DHCFP Medicaid Services Manual, chapter 3100.

Expedited State Fair Hearing: If a recipient sends in a State Fair Hearing request to the DHCFP with clinical documentation that supports the urgency of the request and requests the hearing to be expedited, the hearings unit will send the clinical documentation for medical review by an impartial, third-party physician. If the physician determines the time otherwise permitted for a standard fair hearing decision, ninety days (90) calendar days, could jeopardize the individual's life, health, or ability to attain, maintain or regain maximum function, a hearing decision will be issued within three working days. Anthem's clinician (Medical Director) and Anthem's attorney will need to represent themselves at the expedited State Fair Hearing as is the current process for standard State Fair Hearings. The expedited State Fair Hearings are all held telephonically due to time constraints. If the recipient does not receive an expedited State Fair Hearing, the hearing request will be treated as a standard fair hearing request. Expedited State Fair Hearings will be held by sister agency, the Division of Welfare and Supportive Services (DWSS). Please see the updated Medicaid Service Manual, "Chapter 3100: Hearings" for details.

Note: Providers may file an expedited request *only* in cases where the recipient is unable to act on their own behalf, either because of physical incapacity or mental incapacity. Additional documentation may be required to demonstrate the incapacity on a case-by-case basis. (MLT 03/18 MSM Chapter 3100)

The Provider State Fair Hearing form can be found on the provider website under Forms section.

15.6 Provider Reconsideration Process

You have the right to interact with the medical director or peer reviewer following an adverse determination of healthcare service requiring medical necessity determinations.

The reconsideration and peer-to-peer process is intended to provide a mechanism for you to request a review of a decision to deny coverage of healthcare services for reasons of medical necessity or appropriateness. This process would also include cases where denial was made in the following circumstances:

- Disapproval of full or partial payment for a requested healthcare service
- Approval of healthcare services at a lesser scope or duration than the requested services
- Disapproval of requested services and approval of services of an alternative healthcare service

For your request to be accepted, the requested service must arise from a denial of service or treatment due to a failure to meet medical necessity guidelines. You are not required to have the consent of the member in seeking a reconsideration of an original denial.

In reconsidering the decision, the medical director may request input from a specialist provider. If the medical director who made the initial denial is unavailable, another acting medical director will review the request on behalf of the original medical director. If we uphold our original decision, we will send you a letter with our decision. This letter will include your appeal rights. If you do not agree with our decision, you may request a verbal appeal.

Reconsideration

Reconsideration is a written request from the provider asking to re-review a denied or reduced authorization request. For a Reconsideration request, the provider is responsible to provide additional medical information (for example, intensity of service, severity of illness, risk factors) that might not have been submitted with the original/initial request that supports the level of care/services requested.

Peer-to-Peer

Peer-to-peer reviews are a clinician-to-clinician discussion, which give a member's treating or ordering practitioner the opportunity to discuss a medical necessity denial decision with an appropriate health plan Medical Director (or appropriate practitioner). This can occur anytime during the review process, but most often occurs after a denial is issued. The discussion must occur between the medical director/physician advisor and the provider who is directly involved in the member's care to participate in the peer-to-peer review. Of note, a discussion between a health plan Medical Director (or appropriate practitioner) and an advisor who is not involved directly in the care of a member does not qualify as a peer-to-peer.

The number to call to schedule a Peer-to-Peer is **844-396-2330**.

16 CLAIM SUBMISSION AND ADJUDICATION PROCEDURES

16.1 Electronic Data Interchange (EDI)

Anthem uses Availity as its 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 and employers to do business. Network providers must submit claims within 180 days from the date of discharge for inpatient services or from the date of service for outpatient services. Non-network providers must submit claims within 365 days from the date of discharge for inpatient services or from the date of service for outpatient services. Emergency transportation providers must submit claims within 365 days from the last date of service.

Register with Availity:

1. Choose administrator to register your organization
2. When the admin is ready to register, choose the **register button** on the top of the page
3. Select your organization type and complete the registration process
4. Admin should check email to verify account
5. Once the account is verified, admin will agree to the disclaimer, set up your security questions, and change password and set up authorized users.

Advantages of Electronic Data Interchange (EDI):

- Process claims faster by submitting coordination of benefits electronically and fixing errors early with in-system notification and correction
- Reduce overhead and administrative costs by eliminating paper claim submissions

Use Availity for the following EDI transactions:

- Healthcare Claim: Professional (837P)
- Healthcare Claim: Institutional (837I)
- Healthcare Claim: Dental (837D)
- 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)

Ways you can use the Availity EDI Gateway

Availity's EDI submission options:

- EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software)
- Or use your existing clearinghouse or billing vendor (work with your vendor to ensure connection to the Availity EDI Gateway)

To become an EDI Trading Partner visit www.availity.com.

Login if already an Availity user, choose **My providers > Transaction Enrollment**, or choose **Register** if new to Availity.

EDI Rejections

Claims submitted electronically will return reports that may contain rejections. If using a Clearinghouse or Billing Vendor, please ensure you are receiving all reports. It is important to review rejections on the EDI reports as they will not continue for claims processing. For questions on electronic rejections contact your Clearinghouse or Billing Vendor or Availity if you submit directly at **800- AVAILITY (800-282-4548)**.

Availity's Payer ID — 00265

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

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 Enroll Safe (<https://enrollsafe.payeehub.org/>) to register and manage EFT account changes.

Reimbursement Requirements and Policies

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

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

Unless otherwise noted within the policy, our policies apply to participating providers and facilities; a non-contracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

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

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

Electronic Remittance Advice (ERA) Registration

The 835 eliminates the need for paper remittance reconciliation.

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

1. Log in to **Availity**: <https://apps.availity.com/availity/web/public.elegant.login>
2. Select **My Providers**
3. Select **Enrollment Center** and select **Transaction Enrollment**

Note: If you use a clearinghouse, billing service or vendor, please work with them on ERA registration.

Contact Availity

If you have any questions, please contact Availity Client Services at **800-AVAILITY (800-282-4548)**

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 ongoing 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.

16.2 Paper Claims Submission

You also have the option of submitting paper claims. All claims should be submitted on original red claim forms (not black and white or photocopied forms), laser printed or typed (not handwritten) in a large, dark font. Network providers must submit a properly completed UB-04 CMS-1450 or CMS-1500 (08-05) within 180 days from the date of discharge for inpatient services or from the date of service for outpatient services. Non-network providers must submit properly completed claims within 365 days from the date of discharge for inpatient services or from the date of service for outpatient services. Emergency transportation providers must submit claims within 365 days from the last date of service. Exceptions to these timely filing requirements are in cases of coordination of benefits (COB)/subrogation or in cases where a member has retroactive eligibility. For cases of COB/subrogation, the time frames for filing a claim will begin on the date the third-party documents a resolution of the claim.

CMS-1500 (08-05) and UB-04 CMS-1450 forms are available from CMS at <https://www.cms.hhs.gov>.

CMS-1500 (08-05) and UB-04 CMS-1450 must include the following information (*HIPAA-compliant* where applicable):

- Member's ID number
- Member's name
- Member's date of birth
- ICD-10 diagnosis code/revenue codes
- Date of service
- Place of service
- Procedures, services or supplies rendered CPT-4 codes/HCPCS codes/DRGs
- Itemized charges
- Days or units
- Provider's TIN
- Provider's name according to contract
- Anthem provider number
- NPI of billing and rendering provider when applicable
- CLIA Identification number when applicable (CMS-1500 only)
- COB/other insurance information
- Authorization/precertification number or copy of authorization/precertification
- Name of referring physician
- NPI/API
- Any other state-required data

We cannot accept claims with alterations to billing information. Claims that have been altered will be returned to you with an explanation of the reason for the return. We will not accept claims from you if you submit entirely handwritten claims.

Paper claims must be submitted to the following address:

Anthem Blue Cross and Blue Shield Healthcare Solutions
Nevada Claims
P.O. Box 61010
Virginia Beach, Virginia 23466-1010

Through claims and encounter data submissions, HEDIS information is collected. This includes but is not limited to the following:

- Preventive services (for example, EPSDT, well-child visits, immunizations, mammography, Pap smears)
- Prenatal and postpartum care
- Acute and chronic illnesses
- Others listed in **Appendix B** — HEDIS Measures Desktop Reference for Medical Providers

Compliance is monitored by Anthem Utilization Management and Quality Improvement staff, coordinated with the medical director, and reported to the quality management committee on a quarterly basis. The PCP is monitored for compliance with reporting of utilization.

16.3 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 we often use the term ICD-10 alone, there are actually two parts to ICD-10:

- Clinical modification (CM): ICD-10-CM is used for diagnosis coding.
- Procedure coding system (PCS): ICD-10-PCS is used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States.

ICD-10-CM replaces the code sets ICD-9-CM, volumes one and two for diagnosis coding, and ICD-10-PCS replaces ICD-9-CM, volume three for inpatient hospital procedure coding.

16.4 Encounter Data

We maintain a system to collect member encounter data. Due to reporting needs and requirements, network providers who are reimbursed by capitation must send encounter data to us for each member encounter. Encounter data can be submitted through EDI submission methods or on a CMS-1500 (08-05) claim form unless we have approved other arrangements. Data will be submitted in a timely manner but no later than 180 days from the date of service.

The encounter data will include the following:

- Member's name (first and last name)
- Member's date of birth
- Provider's name according to contract
- Anthem provider number
- Coordination of benefit information
- Date of encounter
- Diagnosis code
- Types of services provided (utilizing current procedure codes and modifiers if applicable)
- Provider's TIN
- NPI/API number

Through claims and encounter data submissions, HEDIS information is collected. This includes, but is not limited to, the following:

- Preventive services (for example, childhood immunization, mammography, Pap smears)
- Prenatal care (for example, LBW, general first trimester care)
- Acute and chronic illness (for example, ambulatory follow-up and hospitalization for major disorders)

Compliance is monitored by our Utilization Management and Quality Improvement staff, coordinated with the medical director, and reported to the quality management committee on a quarterly basis. The PCP/PCS is monitored for compliance with reporting of utilization. Lack of compliance will result in training and follow-up audits and could result in termination.

16.5 Claims Adjudication

We are dedicated to providing timely adjudication of provider claims for services rendered to members. All network and non-network provider claims submitted for adjudication are processed according to generally accepted claims coding and payment guidelines. These guidelines comply with industry standards as defined by the CPT-4 and ICD-10 manuals. Institutional claims should be submitted using EDI submission methods or a UB-04 CMS-1450 and provider services using the CMS-1500.

Providers must use *HIPAA*-compliant billing codes when billing us. This applies to both electronic and paper claims. When billing codes are updated, you are required to use appropriate replacement codes for submitted claims. We will not pay any claims submitted using noncompliant billing codes.

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

For claims payment to be considered, in-state network/non-network providers must adhere to the following time limits:

- Submit claims within 180 days from the date the service is rendered or, for inpatient claims filed by a hospital, submit within 180 days from the date of discharge.
- Claims for members whose eligibility has not been added to the state's eligibility system must be received within 180 days from the date when the eligibility is added and we are notified of the eligibility/enrollment.
- Claims submitted after the 180-day filing deadline will be denied.
- If other health insurance exists, the claim for services may be submitted up to 180 days from the date on the EOP for network providers.

For claims payment to be considered, non-network out of state providers and emergency transportation providers must adhere to the following time limits:

- Submit claims within 365 days from the date the service is rendered or, for inpatient claims filed by a hospital, submit within 365 days from the date of discharge.
- Claims for members whose eligibility has not been added to the state's eligibility system must be received within 365 days from the date the eligibility is added and we are notified of the eligibility/enrollment.
- Claims submitted after the 365-day filing deadline will be denied.
- If other health insurance exists, the claim may be filed up to 365 days from the date on the EOP.

After filing a claim with us, review the weekly EOP. If the claim does not appear on an EOP within 30 calendar days as adjudicated or you have no other written indication that the claim has been received, check the status of your claim online at <https://providers.anthem.com/nv> or call the Provider Inquiry

Line at **844-396-2330**. If the claim is not on file with us, for network providers, resubmit your claim within 180 days from the date of service and, for non-network providers and emergency transportation providers, resubmit your claim within 365 days from the date of service. If filing electronically, check the confirmation reports for acceptance of the claim that you receive from your EDI or practice management vendor.

16.6 Clean Claims Payment

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

- Is timely submitted by provider.
- Is accurate.
- Is submitted on a *HIPAA*-compliant standard claim form, including a CMS-1500 (08-05) or UB-04 CMS-1450 or successor forms thereto or the electronic equivalent of such claim form.
- Requires no further information, adjustment, or alteration by the provider or by a third party in order to be processed and paid by us.
- Is not from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity.

Claims with errors originating from the state's claim system are considered clean.

Clean claims are adjudicated to a paid or denied status within 30 calendar days of receipt. If we do not pay the claim within 30 calendar days of adjudicating the clean claim to an approved or denied status, we will pay all applicable interest as required by law.

We produce and send an EOP, which delineates the status of each claim that has been adjudicated during the previous claim cycle. If a claim is partially or totally denied due to lack of submission of required information, the remittance advice will specifically identify the required information or documentation necessary to complete claim processing. Upon receipt of the requested information from you, we must complete processing of the clean claim within 30 calendar days.

Paper claims that are determined to be unclean will be returned to the billing provider along with a letter stating the reason for the rejection. Electronic Data Interchange (EDI) claims that are determined to be unclean will be returned to our contracted clearinghouse that submitted the claim.

In accordance with Nevada Revised Statute requirements, we will adjudicate 100% of clean claims within 30 days of receipt to an approved or denied status. In accordance with federal requirements, 90% of these will be paid with 30 days of receipt. To further meet NRS requirements, we will pay at least 95% of claims within 30 days of the date they are approved or at least 90% of the total dollar amount for approved claims. In addition, to further meet federal requirements, 99% of all the claims will be paid within 90 days. The date of receipt is the date we receive the claim as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

16.7 Claims Status

Providers can confirm the status and payment detail of their claims by logging in to [Availity Essentials](#)

with their username and password. When viewing the status of a claim on Availity, there may be options available to submit medical records or an itemized bill or dispute the claim.

From Availity's home page, select Claims & Payments> Claim Status.

Access Chat with Payer through Availity Payer Spaces or call the automated Provider Inquiry Line at **844-396-2330** to check claims status.

If claims were electronically submitted make sure you check your response reports for rejections. If you use a clearinghouse vendor, ensure they are supplying your organization with the reports.

16.8 Provider Reimbursement

PCP/PCS Reimbursement

We reimburse PCPs/PCSs according to their contractual arrangement.

Specialist Reimbursement

Reimbursement to network specialty care providers and network providers not serving as PCPs/PCSs is based on their contractual arrangement with us.

Specialty care providers will obtain PCP/PCS and our approval prior to rendering or arranging any treatment that is beyond the specific treatment authorized by the PCP's/PCS's referral or beyond the scope of self-referral permitted under this program.

Overpayment Process

Refund notifications may be identified by two entities, Anthem and its contracted vendors or the providers. Anthem researches and notifies the provider of an overpayment requesting a refund check. The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

Once an overpayment has been identified by Anthem, Anthem will notify the provider of the overpayment. The overpayment notification will include instructions on how to refund the overpayment.

If a provider identifies an overpayment and submits a refund, a completed *Refund Notification Form* specifying the reason for the return must be included. This form can be found on the provider website at <https://providers.anthem.com/nv>. The submission of the *Refund Notification Form* will allow Cost Containment to process and reconcile the overpayment in a timely manner. For questions regarding the refund notification procedure, please call Provider Services at **844-396-2330** and select the appropriate prompt.

In instances where we are required to adjust previously paid claims to adhere to a new published rate, we will initiate a reconciliation of the affected claims. As such, we will determine the cumulative adjusted reimbursement amount based on the new rates. In the event the outcome of this reconciliation results in a net amount owed to us, we will commence recovery of such amounts through an offset against future claims payments. Such recoveries are not considered part of the overpayment recovery process described above or in the provider agreement.

Changes addressing the topic of overpayments have taken place with the passage of the Member Protection and Affordable Care Act (PPACA), commonly known as the Healthcare Reform Act.

The provision directly links the retention of overpayments to false claim liability. The language of 42 U.S.C.A. § 1320a-7k makes explicit that overpayments must now be reported and returned to states or respective MCOs within 60 days of identification of the overpayment or by the date any corresponding cost report is due, whichever is later. After 60 days, the overpayment is considered a false claim, which triggers penalties under the False Claims Act including treble damages. To avoid such liability, healthcare providers and other entities receiving reimbursement under Medicare or Medicaid should implement policies and procedures on reporting and returning overpayments that are consistent with the requirements in the PPACA.

The provision entitled “Reporting and Returning Overpayments — Deadline for Reporting and Returning Overpayments,” codified at 42 U.S.C.A. § 1320a-7k, clarifies the uncertainty left by the 2009 Fraud Enforcement and Recovery Act. This provision of the HealthCare Reform Act applies to providers of services, suppliers, Medicaid managed care organizations, Medicare Advantage organizations and Medicare Prescription Drug Program sponsors. It does not apply to beneficiaries.

Global Payment for Obstetrical Services

A global payment will be paid to the delivering obstetrician when the member has been seen seven or more times. If the obstetrician has seen the member less than seven times, the obstetrician will be paid according to the Medicaid FFS visit-by-visit schedule.

Included services are:

- Prenatal visits.
- Office visits.
- All postpartum visits.
- Radiology services.
- CBC.
- Urinalysis.
- Pregnancy tests.
- One ultrasound.
- Fetal stress test when performed in the physician’s office.

Appropriate CPT codes include 59400, 59510, 59610 and 59618.

16.9 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, 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, wet/dry pads, 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 of 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 <ul style="list-style-type: none"> • 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
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

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
0220, 0949	Stat Charges
0270 – 0279, 0360	Video Equipment Used in Operating Room
0270, 0271, 0272	<p>Supplies and Equipment</p> <ul style="list-style-type: none"> • 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

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
	<ul style="list-style-type: none"> • 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 • 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,

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
	sets, transducers, fluid warmers, heparin, and saline flushes, etc.)
0220 – 0222, 0229, 0250	<ul style="list-style-type: none"> • 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)
0250 – 0259, 0636	Pharmacy (non-formulary drugs, compounding fees, nonspecific descriptions) <ul style="list-style-type: none"> • Medication prep • Nonspecific descriptions

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
	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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

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
	<ul style="list-style-type: none"> • 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 • 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

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
	<ul style="list-style-type: none"> • Retractors • Single Instruments • Oximeter Monitor • CPM Machines • Lasers • Da Vinci Machine/Robot
0370 – 0379, 0410, 0460, 0480 – 0489	<p>Anesthesia</p> <ul style="list-style-type: none"> • Nursing care • Monitoring • Intervention • Pre- or Post-evaluation and education • IV sedation and local anesthesia if provided by RN • Intubation/Extubation • CPR
0410	<p>Respiratory Functions:</p> <ul style="list-style-type: none"> • 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

16.10 Coordination of Benefits and Third-Party Liability

State-specific guidelines will be followed when COB procedures are necessary. We agree to use covered medical and hospital services whenever available or other public or private sources of payment for services rendered to members in our plan.

If primary insurance exists for a member, providers are required to bill a member's primary health plan (PHP) prior to billing Anthem. Providers are required to follow other payers' billing requirements. If the other payer denies a claim because the provider did not follow their requirements, Anthem will also deny the claim. Providers may not collect payment from a member because the provider did not comply with the policies of the PHP and/or Anthem.

If the provider does not participate in a member's PHP, the provider must refer the member to the PHP. Anthem will deny payment for services if the member elects to seek treatment from a provider not participating in the PHP network. If the Medicaid member is informed by a provider not authorized by the PHP that both the PHP and Anthem may deny payment for the services, and the member then voluntarily elects to receive services from a provider who does not participate in the member's PHP, the member assumes the responsibility to pay for the services personally.

Anthem becomes the primary payer under the following conditions:

If the PHP does not cover a service, Anthem becomes the primary health insurance and is responsible within the scope of Anthem rules.

When PHP has exhausted: The provider must provide to Anthem the EOB from the primary carrier showing the services that are exhausted and/or a letter explaining the benefit determination or member termination from the plan.

Anthem and our providers agree the Medicaid program will be the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicaid members. When we're aware of these resources prior to paying for a medical service, we'll avoid payment by either rejecting a provider's claim and redirecting you to bill the appropriate insurance carrier (unless certain pay and pursue circumstances apply — see below), or if we do not become aware of the resource until sometime after payment for the service was rendered, by pursuing post payment recovery of the expenditure. You must **not** seek recovery in excess of the Medicaid payable amount, or the amount agreed upon in the provider agreement with Anthem.

The 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
- Designated behavioral health services (typically not covered by major medical health plans) if the billed services contain one of the following procedure codes:
 - H0043-H0044 (supported housing)
 - H2014-H2018 (skills training, community support and psychosocial rehab)
 - H2023-H2027 (employment support)
 - H0038 (peer support)
 - T1016, T2022, T2023, H0036, H0037, H0039, H0049, H2015, H2016 (behavioral health case management services)

- H0031 (mental health assessments)
- H0019 (behavioral health residential without room and board)
- S9484, S9485 (crisis intervention)
- Any service rendered to a child of an absent parent (for example, primary coverage is through a noncustodial parent after a divorce)

We will also avoid payment of trauma-related claims where third-party liability (TPL) resources are identified prior to payment. Otherwise, we will follow a pay-and-pursue policy on prospective and potential subrogation cases. Paid claims are reviewed and researched post payment to determine likely cases, with multiple letters and phone calls being made to document the appropriate details. The filing of liens and settlement negotiations are handled internally and externally via our subrogation vendor.

We will require members to cooperate in the identification of any and all other potential sources of payment for services.

Any questions or inquiries regarding paid, denied or pending claims should be directed to Provider Services at **844-396-2330**.

16.11 Billing Members

Overview

Before rendering services, you should always inform members the cost of services not covered by Anthem or Nevada Medicaid will be the member's responsibility.

If you choose to provide services not covered by Anthem or Nevada Medicaid, you:

- Understand we only reimburse for services that are medically necessary, including hospital admissions and other services.
- Will obtain the member's signature on the Client Acknowledgment Statement (below) specifying the member will be held responsible for payment of services.
- Understand you may not bill for or take recourse against a member for denied or reduced claims for services within the amount, duration, and scope of benefits of the Medicaid program.

Our **members must not be balance-billed** for the amount above that which is paid by Anthem for covered services.

In addition, you may not bill or charge members a fee for any of the following:

- Failure to timely submit a claim, including claims not received by us
- Failure to submit a claim to us for initial processing within the 180-day filing deadline for network providers or the 365-day deadline for non-network or emergency transportation providers
- Failure to submit a corrected claim within the clean claim submission period
- Failure to appeal a claim within the 180-day payment dispute period
- Failure to appeal a utilization review determination within 30 days of notification of coverage denial
- Submission of an unsigned or otherwise incomplete claim
- Your errors made in claims preparation, claims submission or the appeal/dispute process

- Failure to submit a claim to us within specified time frames for those services covered with other health insurance
- No-show or cancelled appointments
- The first copy of their medical records

Please see *42 CFR § 438.106* and *Nevada Medicaid Service Manual § 105.3* as support for these Anthem policies.

Client Acknowledgment Statement

You may bill our member for a service that has been denied as not medically necessary or not a covered benefit only if both of the following conditions are met:

- The member requests the specific service or item.
- The provider obtains and keeps a written acknowledgement statement signed by the member and the provider stating:

“I understand that, in the opinion of (provider’s name), the services or items 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 be an Anthem-covered benefit. I understand Anthem has established the medical necessity standards for the services or items I request and receive. I also understand 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 covered benefits.”

Signature: _____

Date: _____

Table 10: Average, Minimum, and Maximum Time Spent by Providers Conducting Manual, Partial and Electronic Transactions, Medical, 2019 CAQH Index

Transaction	Method	Average Time Providers Spend per Transaction (minutes)	Min Time Providers Spend per Transaction (minutes)	Max Time Providers Spend per Transaction (minutes)	Potential Average Time Saving (minutes)
Eligibility and Benefit Verification	Manual	10	3	30	8
	Partial	5	1	15	3
	Electronic	2	<1	10	
Prior Authorization	Manual	21	3	45	17
	Partial	8	1	20	4
	Electronic	4	<1	18	
Claim Submission	Manual	6	1	25	4
	Electronic	2	<1	6	
Attachments	Manual	11	1	30	6
	Electronic	5	1	10	
Claim Status Inquiry	Manual	12	1	20	8
	Partial	4	1	10	0
	Electronic	4	<1	11	
Claim Payment	Manual	5	<1	11	2
	Electronic	3	<1	10	
Remittance Advice	Manual	7	<1	19	5
	Partial	4	<1	10	2
	Electronic	2	<1	10	
Total Potential Time Savings (Manual)					50
Total Potential Time Savings (Partial)					9

Supplement statement

This supplement outlines the digital tools Anthem has available to participating and nonparticipating providers who serve its members. It is our expectation that providers will utilize these digital tools unless mandated by law or other legal requirement no later than January 1, 2021. The electronic tools and applications include the secure Availity Provider website, Electronic Data Interchange (EDI)

Transaction Gateway and available business-to-business (B2B) application programming interfaces (APIs) — all hosted via Availity. This supplement addresses the following processes:

- Acceptance of digital ID cards
- Eligibility and benefit inquiry and response
- Claim submission, including attachments and claim status
- Remittances and payments

It is preferred that in markets where these tools are currently available, these digital alternatives are used:

- Disputes
- Grievances and appeals
- Demographic updates
- Pharmacy prior authorization drug requests
- Services through Anthem affiliates, Carelon Medical Benefits Management, Inc. and Carelon Behavioral Health, Inc.
- Provider enrollment
- Prior authorization submissions including updates, attachments, and authorization status

Anthem expects that all providers seeking any functions and processes above will use available electronic self-service tools, including EDI X12 transactions, the Availity Provider website or direct desktop integration via B2B APIs in lieu of manual channels (paper, mail, fax, call, etc.). Availity provides access to all Anthem self-service tools across all electronic channels outlined above. All digital channels are consistent with industry standards.

Access to all Anthem digital tools and capabilities is available on the secure Availity Provider website via <https://www.availity.com>. Please access Availity to learn more about available EDI, the Availity Provider website, and B2B API options. Administration simplification standard transaction requirements: <https://www.hhs.gov/HIPAA/for-professionals/other-administration-simplification-rules/index.html>

***Note:** As a mandatory requirement, all trading partners who currently transmit directly to an Anthem EDI Gateway must transition to the Availity EDI Gateway and have an active Availity Trading Partner Agreement in place.*

SECTION I

Acceptance of digital ID cards

As our members transition to electronic member ID cards, providers may need to implement changes in their processes to accept this new format. Anthem expects that providers will accept the electronic version of the member identification card in lieu of a physical member identification card when presented by members who are transitioning to digital cards.

SECTION II

Eligibility and benefit inquiry and response

Providers may leverage any of the following Availity hosted channels for electronic eligibility and benefit inquiry and response:

- EDI transaction: X12 270/271 — eligibility inquiry and response (version 5010):
 - Anthem supports the industry standard X12 270/271 transaction set for eligibility and benefit inquiry and response as mandated by *HIPAA*.
- Secure Availity Provider website:
 - Eligibility and benefit verification utility — This utility allows a provider to key an inquiry directly into an online eligibility and benefit look-up form with real-time responses.
- Provider desktop integration via B2B APIs:
 - Anthem has also enabled real-time access to eligibility and benefit verification APIs that can be directly integrated within participating vendors' practice management software, revenue cycle management software and some electronic medical records software. Contact Availity for available vendor integration opportunities at <https://www.availity.com/Healthcare-APIs>.

SECTION III

Authorizations

Prior authorization submission, attachment, and status

Providers may leverage any of the following channels for prior authorization submission, status inquiries and submission of electronic attachments (solicited or unsolicited) on the secure Provider website via Availity:

- EDI transaction: X12 278 — prior authorization and referral (version 5010):
 - Anthem supports the industry standard X12 278 transaction for prior authorization submission and status inquiry as mandated per *HIPAA*.
- EDI transaction: X12 275 — patient information, including HL7 payload (version 5010) for authorization attachments:
 - Anthem supports the industry standard X12 275 transaction for electronic transmission of supporting authorization documentation including medical records via the HL7 payload.
- Secure Availity Essentials secure multi-payer website:
 - The authorization application allows a provider to key a prior authorization request, including an attachment or status inquiry directly into an online form.
 - Additionally, providers can use the digital authorization application to make inquiries on previously submitted requests, regardless of how the original prior authorization was submitted (phone, fax, eReview, secure email, etc.).
- Provider desktop integration via B2B APIs:
 - Anthem has enabled real-time access to prior authorization APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software and some electronic medical records software. Contact Availity for available vendor integration at: <https://www.availity.com/Healthcare-APIs>.

SECTION IV Claims: submissions, attachments and status

Claim submissions, attachment, and status

Providers may leverage any of the following channels for electronic claim submission, attachments (for both pre- and postpayment) and status on the secure Availity provider website:

- EDI transaction: X12 837 — professional, institutional, and dental claim submission (version 5010):
 - Anthem supports the industry standard X12 837 transactions for all fee-for-service and encounter billing as mandated per *HIPAA*.
- EDI transaction: X12 275 — patient information, including HL7 payload attachment (version 5010):
 - Anthem supports the industry standard X12 275 transaction for electronic transmission of supporting claims documentation including medical records via the HL7 payload.
- EDI transaction: X12 276/277 — claim status inquiry and response (version 5010):
 - Anthem supports the industry standard X12 276/277 transaction set for claim status inquiry and response as mandated by *HIPAA*.
 - Secure Availity Provider website: Direct Data Entry (DDE) — The claim DDE utility provider allows a provider to key a claim directly into an online claim form and also upload supporting documentation for a defined claim (solicited or unsolicited).
 - 837 Claim batch upload — The claim batch upload utility allows a provider to upload an entire batch/file of claims (must be in X12 837 standard format).
 - Claim Status Inquiry utility — This utility allows a provider to key an inquiry directly into an online claim status form with real-time responses.
- Provider desktop integration via B2B APIs:
 - Anthem has also enabled real-time access to claim status via APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software and some electronic medical records software. Contact Availity for available vendor integration at <https://www.availity.com/Healthcare-APIs>.

SECTION V Remittances and payments electronic funds transfer

Like the payroll direct deposit service that most businesses offer their employees, electronic funds transfer (EFT) uses the automated clearing house (ACH) network to transmit healthcare payments from a health plan to a healthcare provider's bank account. Health plans can use a provider's banking information only to deposit funds, not to withdraw funds. Anthem expects providers to accept payment via EFT in lieu of paper checks.

Providers can register or manage account changes for EFT via the enrollment tool called **EnrollSafe™**. This tool will help eliminate the need for paper registration, reduce administrative time and costs and allows physicians and facilities to register with multiple payers at one time. EFT payments are deposited faster and are generally the lowest cost payment method.

To facilitate quicker reimbursement for providers who have not enrolled for EFT, Anthem may move paper checks to a virtual card payment method. Virtual cards allow physicians and facilities to process payments as credit card transactions.

Using the same Trace Identifier Segment (TRN) helps to match the payment to the correct remittance advice, a process called reassociation. Health plans are required to input the X12 835 TRN segment into Field 3 of the *Addenda Record of the CCD+Addenda*. The TRN segment in the *Addenda Record of the CCD+Addenda* should be the same as the TRN segment in the associated ERA that describes the payment.

Electronic Remittance Advice (ERA)

Providers may leverage any of the following channels for electronic remittance advice (ERA) on the secure Availity Essentials:

- EDI transaction: X12 835 — ERA (version 5010)
 - Anthem supports the industry standard X12 835 transaction as mandated per *HIPAA*. Work with your EDI vendor or clearinghouse to get registered.
- Availity Essentials — remittance inquiry:
 - The Remittance Inquiry application provides a digital version (PDF) of paper payment remittance that can be downloaded.

* Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan.

* Carelon Behavioral Health, Inc is an independent company providing utilization management services on behalf of the health plan.

* CarelonRx, Inc. is an independent company providing pharmacy benefit management services on behalf of the health plan.



Provider Services: 844-396-2330
<https://providers.anthem.com/nv>

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