Anthem Blue Cross and Blue Shield Healthcare Solutions
Medicaid Managed Care

Provider orientation

For providers with Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem) seeing Nevada Medicaid members

NVBCBS-CD-080705-25 March 2025

Agenda

- About us
- Who we serve
- Joining our network
- Claims tools and resources
- Provider programs
- Quality management
- Delegated services
- Provider resources

About us

Community Care Heath Plan of Nevada, Inc., doing business as Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem), is a leader in managed health care services for the public sector. We provide health care 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 health care market. We coordinate our members' physical and behavioral health care, offering a continuum of education, access, care and outcome programs, resulting in lower cost, improved quality and better health status for Americans.

Who we serve

Nevada Medicaid

Medicaid provider health care coverage for many people including low-income families with children whose family income is at or below 133% of poverty line, Supplemental Security Income (SSI) recipients, recipients of adoption assistance, foster care and some children aging out of foster care. The Division of Health Care Financing and Policy (DHCFP) also operates five Home- and Community-Based Services waivers offered to certain persons throughout the state.

Nevada Check Up

Nevada Check Up provides health care benefits to uninsured children from low-income families who are not eligible for Medicaid but whose family income is at or below 200% of the Federal Poverty Line. Information regarding the Nevada Check Up program is available by calling us toll free at **1-877-543-7669**.

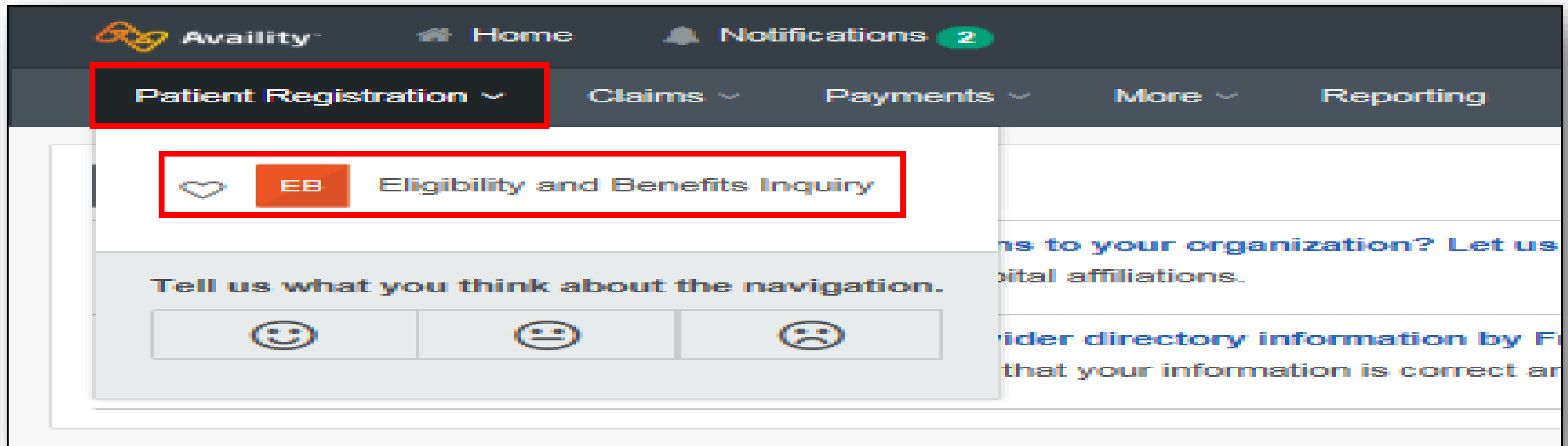
Member eligibility

- Eligibility of Nevada Medicaid members is determined by the Division of Welfare and Supportive Services (DWSS). DWSS notifies the state's fiscal agent, who enrolls members.
- Nevada Medicaid and Nevada Check Up members who meet the state's eligibility requirements for participation in managed care are eligible to join our health care plan.
- We do not discriminate against eligible members based on their health status or need for health services. We will not deny the enrollment of or discriminate against any Nevada Medicaid or Nevada Check Up member eligible to enroll on the basis of race, color or national origin and will not use any policy or practice that has the effect of discrimination on the basis of race, color or national origin.

Member eligibility verification

Verifying eligibility

- Verify member eligibility through the electronic verification system (EVS) website prior to every visit at https://www.medicaid.nv.gov/hcp/provider/Home/tabid/135/Default.aspx.



General member rights

Members have the right to:

- Receive understandable notices or have program materials explained or interpreted.
- Receive timely information about the health plan.
- Receive courteous, prompt answers from the health plan and DWSS.
- Be treated with respect.
- Have their privacy protected by the DWSS, the health plan and its providers.
- Receive information about all medical and behavioral health services covered by Anthem.

General member rights (cont.)

Members have the right to:

- Choose their health plans and PCPs from available health plans and contracted networks.
- Receive proper medical care consistent with our member handbook and without discrimination regarding health status or conditions, gender, ethnicity, race, marital status or religion.
- Choose a PCP who is part of the Anthem network and refuse care from specific PCPs and providers.
- Participate in the decision-making process for their health care.

For a complete summary of members' rights, reference the provider manual.

General member responsibilities

Members and/or their enrolled dependents have the responsibility to:

- Understand Nevada Medicaid.
- Understand their health problems and participate in developing mutually agreed-upon treatment goals (to the degree possible).
- Supply information, to the extent possible, that the organization and its practitioners and providers need in order to provide care.
- Accurately and promptly report changes that may affect premiums or eligibility, such as address changes or changes in family status or income, and submit the required forms and documents.

General member responsibilities (cont.)

- Choose a PCP before receiving services. (Members can receive behavioral health services prior to and without referral from PCPs.)
- Work with Anthem to help get any third-party payments for medical care.
- **Notify** Anthem about any outside sources of health care coverage or payments, such as insurance coverage for accidents.
- **Notify** all their providers about medical problems and ask questions about things they do not understand.
- Decide whether to receive treatments, procedures or services.
- **Seek** medical services from (or coordinated by) PCPs, except in emergencies or in the cases of referrals.

Advance directives

- Members have the right to use advance directives to put their health care choices in writing. They may also name someone to speak for them if the member is unable to speak.
- Nevada state law has three kinds of advance directives:
  - **Durable power of attorney for health care** names someone to make medical decisions for the member if they are not able to make their own decisions.
  - **Directive to physicians (living will)** tells doctors what a member does or does not want to happen if a terminal condition arises or if the member becomes permanently unconscious.
  - **Mental health advance directive** describes a member's directions and preferences for mental health treatment when they are having difficulty communicating and/or making decisions including identification of an agent to make decisions on the member's behalf.

Physician Orders for Life-Sustaining Treatment (POLST)

A *POLST* order:

- Allows a seriously ill patient to express end-of-life treatment wishes.
- Provides security for the patient and the physician so the wishes of the patient are carried out.

The form must be signed by the patient and the attending physician, nurse practitioner or physician assistant. The *POLST* form can be located on the provider website under *Provider Forms*.

Member webpage

Members can register and access through a secure account the following services:

- Change their primary care provider
- Send a secure message to Member Services or request a callback
- Print their ID card
- Set mailing preferences
- Manage their prescriptions

Member webpage

Anthem BlueCross BlueShield

NEVADA

Benefits Care Support Your Account A A A Login Español

Nevada Medicaid

Anthem Blue Cross and Blue Shield Healthcare Solutions provides all your Nevada Medicaid benefits, like care from a PCP you choose, pharmacy benefits, preventive care and more — all at no cost to you. We know health care is about more than just doctor visits, so our benefits are designed to make a difference in your life.

Enroll Renew

Tools

Find a Doctor

How to Enroll

How to Renew

Your ID Card

Member ID cards

To confirm you are seeing a Nevada Medicaid member, make sure to check that the ID number begins with VNV.

Anthem. BlueCross BlueShield

Medicaid

Member ID

Primary Care Provider (PCP):

Program ID #:
Effective Date:
Date of Birth:

SAMPLE

Anthem. BlueCross BlueShield

Check Up

Member ID

Primary Care Provider (PCP):

Check Up ID:
Effective Date:
Date of Birth:

SAMPLE

Anthem. BlueCross BlueShield

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.

Providers: Certain services must be preauthorized. For preapproval/billing information, call 1-844-396-2330. 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.

Pharmacies: Submit claims using **Express Scripts** RXBIN: 003858; RXPCN: MA; RXGRP: WKKA. For technical help, call Express Scrpts at 1-844-367-6110.

NV01 02/18

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

*Contracts directly with group

Claims Filing Address:
Anthem Blue Cross and Blue Shield
P.O. Box 61599
Virginia Beach, VA 23466-1599

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.

SAMPLE

PCP selection

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 health care. 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 his or her patient, our member. The PCP serves as the entry point into the health care system for the member. The PCP is responsible for the complete care of his or her patient, including providing primary care, coordinating and monitoring referrals to specialist care, authorizing hospital services, and maintaining the continuity of care.

Covered services

- A grid of health care services and benefits we cover for Nevada Medicaid and Nevada Check Up members is available in the *Anthem Health Care Benefits* section of the provider manual.

- The services covered will be administered up to the limits/guidance as outlined in the appropriate Nevada Medicaid service manuals.

Services are subject to inclusions, limitations or exclusions.

Anthem’s value-added benefits

Below is a sample of value-added benefits Anthem covers for Nevada Medicaid and Nevada Check Up members:

- Free cellphone with free monthly minutes, data and text messages
- Additional transportation assistance to provider appointments and health-related services
- *My Wellness Guide* so members can take control of their health and well-being — set goals, track progress and get tips for healthier living
- Bedside delivery of medications to member’s bedside when discharged from a hospital setting
- Free holistic smoking program — smoking cessation to support members age 18 or older and includes telephonic outreach, education, nicotine replacement therapy and coaching
- Transitional care assistance for extra help from hospital to home

A full listing of value-added benefits is available in the *Anthem Health Care Benefits* section of the provider manual.

Behavioral health

Anthem facilitates integrated physical health (PH) and behavioral health (BH) services as an integral part of health care.

Our mission is to address the PH and BH care of members by offering a wide range of targeted interventions, education and enhanced access to care to ensure improved outcomes and quality of life for members.

Visit the Behavioral Health webpage for resources such as:

- *Clinical Utilization Management* guidelines.
- Forms (*Initial Review*, *Concurrent Review*, *Neuropsychological* and *Psychological Testing Request* forms).
- Educational Items.

Behavioral health services

We cover the following services up to the service limit/guidance in the appropriate Nevada Medicaid services manual:

- 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

Resources:

The list of behavioral health services is available in the provider manual — Nevada Medicaid service manuals and chapters

Services are subject to inclusions, limitations or exclusions.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) reminder program

- We are committed to promoting member receipt of age-appropriate preventive health services.
- A list of members who, based on our claims data, may not have received EPSDT services according to schedule is sent to the member's PCP each month.
- Additionally, we mail information to these members encouraging them to contact their PCP to set up an appointment for needed services.
- Visit our provider website for the EPSDT training and toolkits.

Screening, Brief Intervention and Referral to Treatment (SBIRT)

SBIRT is a comprehensive, integrated public health approach to the delivery of early intervention and screening for individuals with risky alcohol and drug use.

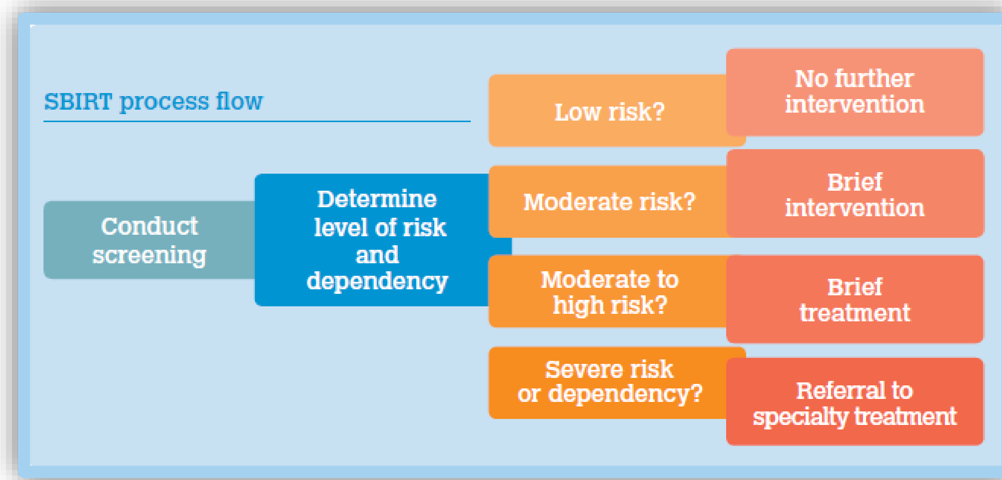
For these patients who are at a high risk of developing a substance use disorder or who are already dependent upon substances, SBIRT helps get them more intensive substance use treatment quickly.

The Substance Abuse and Mental Health Services Administration defines SBIRT as:

- Brief (typically 5-10 minutes for brief intervention and 5-12 minutes for brief treatment).
- Universal.
- Targeting one or more behaviors regarding risky alcohol and drug use.
- Delivered in a public health, nonsubstance abuse treatment setting.
- Comprehensive – comprised of screening and referral.
- Involving research, evaluation and collection of experiential evidence to assess the model's effectiveness.

Delivering SBIRT services

Primary care centers, hospital emergency rooms (ERs), trauma centers and community health settings have the best chance to intervene early with at-risk substance users and prevent more severe consequences. All PCPs (as defined by state law) as well as behavioral health providers play a role in SBIRT.



Disease Management (DM)

- Our DM program is based on a system of coordinated care management interventions and communications designed to assist physicians and others in managing members with chronic conditions.
- The mission of the DM department is to improve the health and quality of life for the members served by encouraging member self-care efforts, coordinating health care education and providing interventions along the continuum of care.
- To refer a patient for DM services or for more information, call us at **1-888-830-4300**:
  - DM case managers are registered nurses and are available from 8:30 a.m. to 5:30 p.m. local time Monday through Friday. Confidential voicemail is available 24/7.

Vaccines for Children (VFC)

You must enroll in the VFC program administered by the Nevada State Health Division. If you're licensed by the state to prescribe vaccines, contact the Nevada State Health Division to enroll. The immunization program will review and approve your enrollment request. As a VFC-enrolled provider, you must cooperate with the Nevada State Health Division 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.

Maternal Child Services

- New Baby, New Life℠ is a proactive case management program for all expectant mothers and their newborns that offers:
  - Individualized, one-on-one case management support for women at the highest risk.
  - Care coordination for moms who may need a little extra support.
  - Educational materials and information on community resources.
  - Rewards to keep up with prenatal and postpartum checkups and well-child visits after the baby is born.
- Members are identified through review of state enrollment files, claims data, lab reports, hospital census reports, provider notification of pregnancy and delivery notification forms, and self-referrals.
- Experienced case managers work with members and providers to establish a care plan.

Maternal Child Services (cont.)

- As part of the New Baby, New Life program, members are offered the My Advocate™ program from Change Healthcare.*
- This program provides pregnant women proactive, culturally appropriate outreach and education through interactive voice response (IVR), text or smartphone application.
- The goal of the expanded outreach is to identify pregnant women who have become high-risk, to facilitate connections between them and our case managers, and improve member and baby outcomes.
- For more information on My Advocate, visit www.myadovcatehelps.com.

* Change Healthcare is an independent company managing the My Advocate program on behalf of Anthem Blue Cross and Blue Shield Healthcare Solutions.

Joining our network

Contracting

Join our network

If you are interested in joining our provider network, please send the following tonv1-providerservices@anthem.com or fax **1-866-495-8711**:

- A letter of intent
- A *W-9*

Adding new providers to an existing practice

If you are already contracted with Anthem and would like to add additional providers, please email nvcredentialing@anthem.com.

Credentialing

- Providers must be enrolled with NV FFS and have a State Medicaid ID
- Providers must be credentialed to be contracted with Anthem.
- Providers can complete their application and submit all required documents at https://www.caqh.org.
- Please email the Network Relations team of any changes in licensure, demographics or participation status at nv1-providerservices@anthem.com.
- Recredentialing occurs every three years or sooner if required by state law.
- Anthem does not do retro-effective dates for credentialing.

It is the provider's responsibility to maintain good standing on their credentialing status. Anthem will proactively *notify* providers in advance on re-credentialing prior to expiring; however, Anthem will not be responsible for the lapse of the credentials.

Provider responsibilities

- Providers should review both member and provider responsibilities, which are detailed in the provider manual.
- Anthem designed our policies to comply with the *Americans with Disabilities Act*.
- Providers are required to remove existing barriers and accommodate the needs of members with disabilities. Examples of removing preventable barriers include:
  - Ensuring street-level access to facilities.
  - The existence of elevators or accessible ramps in or within the facility.
  - Access to a restroom that can accommodate a wheelchair.
  - Access to an examination room that can accommodate a wheelchair.
  - Reserved, clearly marked parking for people with disabilities (unless there is street-side parking).

https://mediproviders.anthem.com/nv

Behavioral Health Areas of Expertise Profile (BHAEP)

The *BHAEP* is designed to capture supplemental data to enhance our online and paper provider directory. This will help our members find the right behavioral health provider for their unique needs:

- There is a *BHAEP* for individual practitioners and facilities.
- Group practices must complete the survey for all participating providers and newly credentialed providers.
- Facilities must complete the survey for all participating locations and newly credentialed locations.
- Your local Network Relations representative can provide information on completing the survey.

Claims, tools and resources

Provider website

[Our provider website]

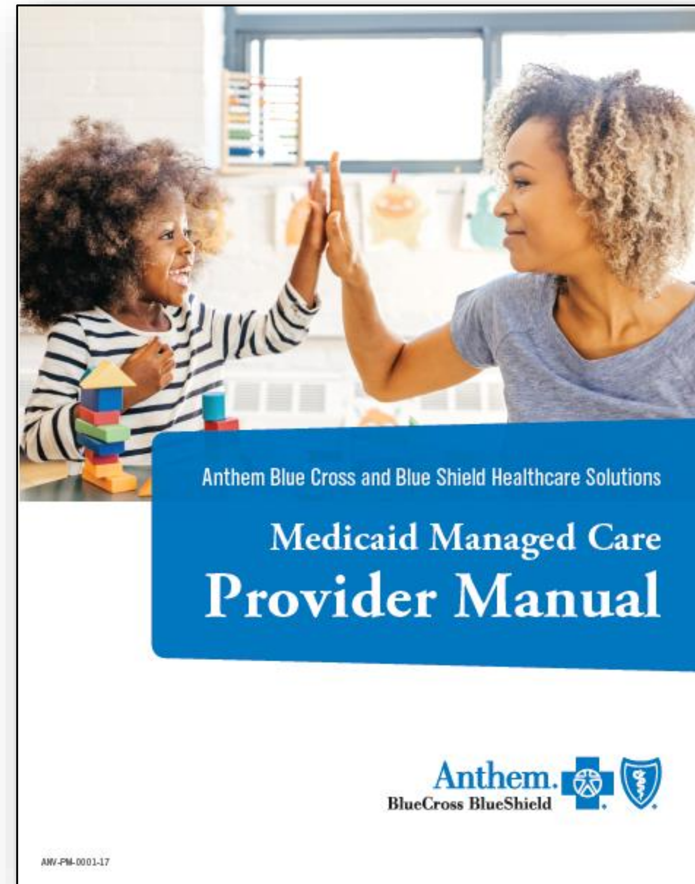
The provider website is available to all providers, regardless of participation status.

The tools on the site allow you to perform key transactions.

Provider manual

The provider manual is located on the provider website at (https://mediproviders.anthem.com/nv/Pages/manuals-directories-training.aspx). Topics covered in the provider manual include:

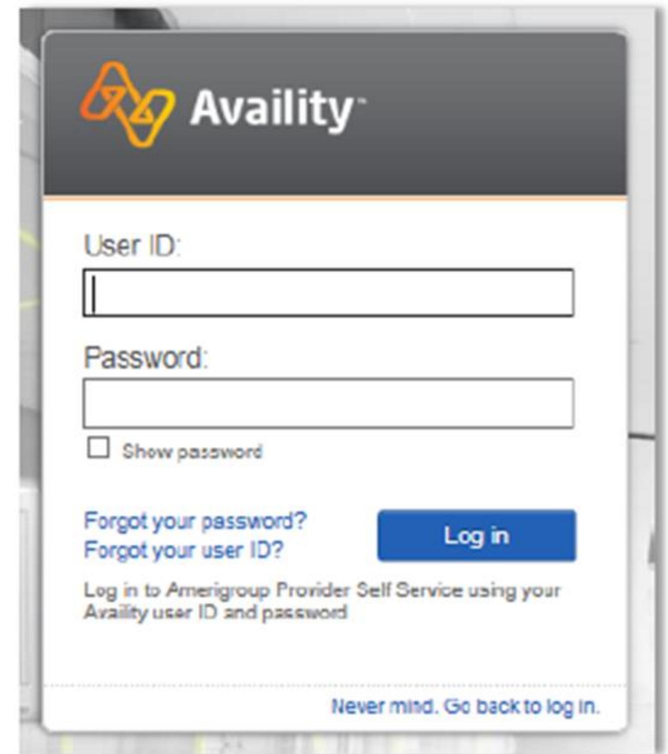
- Prior authorization requirements.
- Covered services for members.
- Provider procedures, tools and support.
- Claim submission.
- Quality management.
- Tools to help you manage members' needs.
- Provider grievance and appeal process.



Availity Portal

Use the Availity Portal* to:

- Review patient eligibility.
- Review benefit information.
- Submit and track claims.
- Appeal claims.
- Submit authorization requests using the Interactive Care Reviewer (ICR) application.



Patient 360 allows you to view secure member demographic and care management details.

* Availity is an independent company that administers the secure provider portal on behalf of Anthem Blue Cross and Blue Shield Healthcare Solutions.

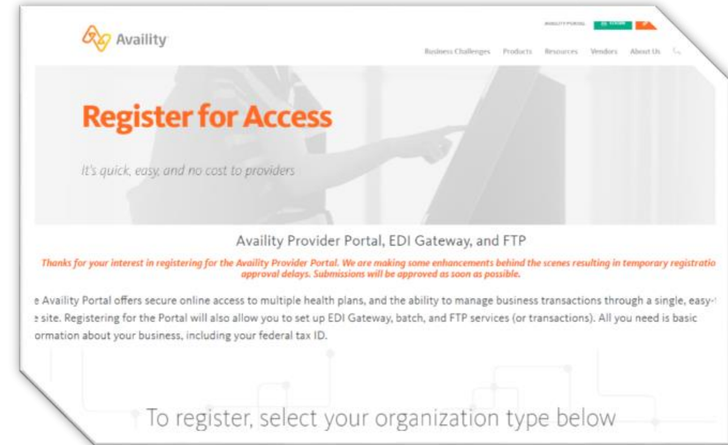
Secure Availity registration

Registration and login **are** required to access the following:

- Prior authorization submission and prior authorization status lookup through Interactive Care Reviewer (ICR)
- Pharmacy precertification
- PCP panel listings
- Member eligibility
- Claim status lookup

Registration for the secured content on Availity is easy:

- Begin by navigating to https://www.availity.com and selecting **Register**.
- There are multiple resources and trainings available to support navigation of the Availity and Anthem websites.



Reports through Availity

- Obtain any one of the following reports through Availity:
  - Eligibility and benefits inquiry
  - Member panel listings
  - Member reports
  - Registration for Provider Online Reporting
- Visit the Availity home page to learn how to download your member panel listings.

Claims overpayment recovery and refund

- 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://mediproviders.anthem.com/nv.
- For questions regarding the refund notification procedure, please call Provider Services at **1-844-396-2330**.

Encounter data

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, low birth weight (LBW), general first-trimester care)
- Acute and chronic illness (for example, ambulatory follow-up and hospitalization for major disorders)
- Both HCPCS and NDC are required for a physician administered drug or injectable in an outpatient setting

Lack of compliance will result in training and follow-up audits and could result in termination.

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

Prior Authorization Look Up Tool

The Prior Authorization Look Up Tool identifies if a specific code requires authorization.

Navigation to Prior Authorization Look Up Tool via the provider webpage.

Prior Authorization Look Up Tool

This tool:

- **Is for outpatient services** — inpatient services always require precertification
- **Does not show benefits coverage** — refer to our state-specific provider manuals for coverage/limitations
- **Please note: Drug description search is case sensitive. You must search using generic/chemical ingredient name and use lower case only.**

Market: Select Market

Line of Business: Select Line Of Business

CPT/HCPCS Code or Code Description:

Submit

Prior authorization

- Note, prior authorization is not required for laboratory services if the lab work is performed in a physician's office or participating hospital outpatient department (if applicable) or by one of our preferred lab vendors:
  - We use Clinical Pathology Laboratories (CPL)* in Southern Nevada.
  - Visit our website for a full list of contracted providers in Northern Nevada.
- To request authorization online for general services, maternity/OB, emergent admission:
  - From the Availity Portal, https://www.availity.com, select **Patient Registration** from the top navigation.
  - Select **Auth/Referral Inquiry** or **Authorizations**.

Clinical Pathology Laboratories is an independent company providing laboratory services on behalf of Anthem Blue Cross and Blue Shield Healthcare Solutions.

Prior authorization

Pharmacy benefit prior authorization requests may be submitted using the following methods:

- Electronic prior authorization (ePA) — Submit electronically through CoverMyMeds* at https://www.covermymeds.com/main.
- Fax — Complete the *Pharmacy Prior Authorization* form and fax to **1-844-490-4876**.

The *Pharmacy Prior Authorization* form is available at: https://mediproviders.anthem.com/Documents/NVNV_CAID_RXPriorAuthFormUpdate.pdf.

Covermymeds is an independent company providing prior authorization review services on behalf of Anthem Blue Cross and Blue Shield Healthcare Solutions.

Prior authorization (cont.)

Medical benefit prior authorization (medical injectable drugs) requests may be submitted using the following method:

- Fax — Complete the *Medical Injectable Prior Authorization* form and fax to **1-844-490-4876**.
- The *Medical Injectable Prior Authorization* form is available at: https://mediproviders.anthem.com/Documents/NVNV_CAID_MedInjectPriorAuth.pdf.

All other prior authorization requests (including elective inpatient or outpatient services) should use the following:

  - Fax: **1-800-964-3627**
  - Phone:**1-844-396-2330**

Prior authorization (cont.)

For durable medical equipment (DME), outpatient rehabilitation (physical therapy [PT]/occupational therapy [OT]/speech therapy [ST]), pain management, home care, home infusion or hyperbaric treatment, and wound care, please fax to **1-866-920-8362**.

Prior authorization (cont.)

- Behavioral health requests for services requiring prior authorization should be faxed to:
  - Inpatient: **1-877-434-7578**
  - Outpatient: **1-800-505-1193**
- Services billed with the following revenue codes always require prior authorization:
  - 0240 to 0249 — all-inclusive ancillary psychiatric
  - 0901, 0905 to 0907, 0913 and 0917 — behavioral health treatment services
  - 0944 to 0945 — other therapeutic services
  - 0961 — psychiatric professional fees

Interactive Care Reviewer (ICR)

Trainings available for ICR features are available at ICR-HELP.

Interactive Care Reviewer

Interactive Care Reviewer (ICR) is an innovative Utilization Management (UM) portal that allows providers to submit prior authorization (PA) requests and clinical information. It also allows providers to receive status updates without having to pick up a phone or fax any information to Amerigroup.

Key Features

- A no cost electronic UM solution
- Instant access from any location at any time of day
- Providers can create a UM PA case and instantly submit it for review
- Providers can attach clinical documents for review — no faxing required
- Enables the ability status check any case regardless of the method used to originally submit them
- Auto authorization for many common procedures
- Complete record of submissions and dispositions — all in one place

Training available via on demand videos

- How to Access Availity and Register
- ICR Dashboard Overview
- ICR End to End Overview
- ICR Detailed End to End Demo
- ICR Provider Favorites & E-mail Notifications
- BH OP ICR Demo
- ICR Immediate Decisions & Templates
- ICR Viewing Letters
- PreC & PreD Outcomes ICR
- Print/Save/View Transaction History
- Updates to an ICR Case
- Viewing Fax & Phone Cases (Auth Inquiry)

Availity

To gain access to ICR and much more go to the Availity Portal

Live Webinars

Register Here to attend the next live ICR Webinar.

Authorization review/peer-to-peer

Authorization review time frame:

- Up to 14 days for nonurgent
- 72 hours for urgent requests

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 reasonable time from the receipt of the denial by calling the local health plan at **1-702-228-1308**, Monday through Friday from 8 a.m. to 5 p.m. Pacific time.

Claims filing limits

- 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.

Billing members

Before rendering services, you should always inform members the cost of services not covered by Anthem will be charged to the member.

If you choose to provide services not covered by Anthem, 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* from the provider manual, 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.

Electronic data interchange (EDI)

We encourage the submission of claims electronically through EDI.

Electronic claims submission is available through:

- Change Healthcare is SB765 for professional and 12B20 for institutional.
- Availity is 00265.
- SDS — please contact the clearinghouse.

To initiate the electronic claims submission process or for additional information, call our EDI Hotline at **1-800-470-9630** or email at e-solutions.support@anthem.com.

For more information, visit our EDI webpage.

Claims — Clear Claim Connection™

The Clear Claim Connection tool is available to help you determine if procedure codes and modifiers will likely pay for your patient's diagnosis.

Clear Claim Connection™

McKesson Edit Development Glossary About Help Logoff

Gender: Male Female

Date of Birth: / / (mm/dd/yyyy)

Click Grid to enter information:

Procedure	Mod 1	Mod 2	Mod 3	Mod 4	Date of Service
					/ /
					/ /
					/ /
					/ /
					/ /

Add More Procedures>>

Review Claim Audit Results Clear

Claims — rejected versus denied claims

There are two types of notices a provider may get in response to claim submission — rejected or denied.

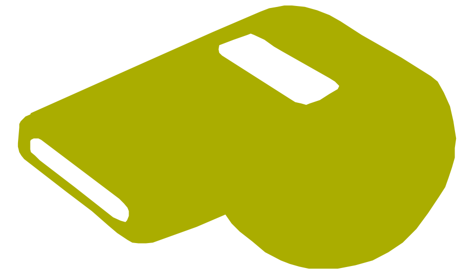
Rejected	Denied
Does not enter the adjudication system due to missing or incorrect information	Goes through the adjudication process but is denied for payment

Claims inquiries and payment disputes

- Our Provider Services unit ensures provider claim inquiries are handled efficiently and in a timely manner.
- Claim inquiry calls are handled by specially trained representatives in Provider Services.
- For assistance, call **1-844-396-2330**.
- To dispute a claim payment, submit a copy of the *Explanation of Payment*, supporting documentation and a *Letter of Explanation*.

Grievances

- We track all provider grievances until they are resolved.
- Reference your provider manual for details regarding filing a grievance, escalation and key contacts.



Medical appeals

- Separate and distinct appeal processes are in place for our members and providers depending on the services denied or terminated.
- Please refer to the denial letter issued to determine the correct appeals process.

Fraud, waste and abuse

Fraud, waste and abuse —
Help us prevent it and
tell us if you suspect it!

- Verify patient's identity.
- Ensure services are medically necessary.
- Document medical records completely.
- Bill accurately.

Fraud, waste and abuse reports can be made through:

- Medicare/Medicaid Fraud Hotline: **1-866-847-8247**
- Compliance and Ethics Hotline: **1-877-660-7890**
- Member Fraud, Waste and Abuse: **1-800-600-4441**

If you suspect or witness fraud, waste or abuse, report it immediately. Providers can report anonymously on the Anthem website or contact their Network Relations consultant.

Provider programs

Medical home

The PCP/PCS is the foundation of the collaborative concept known as a medical home. He or she is responsible for providing, managing and coordinating all aspects of the member's medical care and providing all care that is within the scope of his or her practice.

Quality management

Quality Management (QM) Program

- The QM Program provides a formal process to objectively and systematically monitor and evaluate the quality, appropriateness, efficiency, safety and effectiveness of care and service.
- A multidimensional approach enables us to focus on opportunities for improving operational processes as well as health outcomes and satisfaction of members and providers.
- The QM Program implements and tracks a variety of activities that address the quality and safety of clinical care and quality of service throughout the year.
- If you would like more information on our QM Program, please call **1-702-228-1308** (**TTY 711**).

Quality of care

All physicians, advanced registered nurse practitioners and physician assistants 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.
- Contractual compliance.

These reviews are shared with the practitioners to allow them to increase individual and collaborative rates for members.

Delegated services

Pharmacy services

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 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 and pneumococcal

Pharmacy Services — IngenioRx

IngenioRx*

Computerized point-of-sale (POS) system for participating pharmacies with 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 should submit pharmacy benefit claims to IngenioRx 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.

* IngenioRx, Inc. is an independent company providing pharmacy benefit management services on behalf of Anthem Blue Cross and Blue Shield Healthcare Solutions.

Pharmacy services — *Preferred Drug List (PDL)* and prior authorization drugs

Anthem has a list of drugs you can choose from. It is called a *PDL*. It includes all medicines covered by Medicaid.

Though most medications on the *PDL* are covered without prior authorization, a few agents require you to contact the Pharmacy department for authorization.

You may reach the Pharmacy department at **1-844-396-2330** from 8 a.m. to 7 p.m. Monday through Friday and 10 a.m. to 2 p.m. on Saturday.

Retail pharmacy fax requests: **1-844-490-4874**

Medical injectable fax requests: **1-844-490-4876**

Note: Walgreens and Rite Aid are not part of the pharmacy network.

Pharmacy Member Services

- Pharmacy Member Services: New Call Center Dedicated to Pharmacy Services
- Member Questions:
  - Answered 24/7
  - Pharmacy SMEs answering calls
  - Warm transfers to traditional Member Services for medical questions

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Retail pharmacy fax requests: **1-844-490-4874**

Medical injectable fax requests: **1-844-490-4876**

Our preferred vendors

Laboratory services:	• Clinical Pathology Labs https://www.cpllabs.com/home • LabCorp* https://www.labcorp.com/wps/portal • Quest Diagnostics, Inc.* http://www.questdiagnostics.com
Vision services:	• EyeQuest* http://www.eye-quest.com/providers
Pharmacy:	• IngenioRx www.ingenio-rx.com
Diagnostic and imaging service authorizations:	• AIM Specialty Health® https://www.providerportal.com/

* LabCorp and Quest Diagnostics, Inc. are independent companies providing laboratory services on behalf of Anthem Blue Cross and Blue Shield Healthcare Solutions. EyeQuest is an independent company providing vision services on behalf of Anthem Blue Cross and Blue Shield Healthcare Solutions. AIM Specialty Health is a separate company providing utilization review services on behalf of Anthem Blue Cross and Blue Shield Healthcare Solutions.

Provider resources

Translation services

- Interpreter services are available if needed.
- Free interpreter services are available to our members through CulturaLink* at **1-888-844-1414**.
- Interpreters are available 24/7 in over 200 languages.
- Members who are deaf or hard of hearing should call the toll-free AT&T Relay Service at **TTY 711** or **1-844-396-2329** at least five days before the scheduled appointment.

* CulturaLink is an independent company providing translation services on behalf of Anthem Blue Cross and Blue Shield Healthcare Solutions

24/7 Nurse Help Line

Our Nurse Help Line is a service designed to support the provider by offering information and education about medical conditions, health care and prevention to members after normal physician practice hours. The Nurse Help Line provides triage and crisis management services and helps direct members to appropriate levels of care. The Nurse Help Line telephone number is **1-844-396-2329 (TTY 711)**.

Features of the Nurse Help Line include the following:

- Availability 24 hours a day, 7 days a week
- Information provided is based upon 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
- A nurse faxes the member’s assessment report to the provider’s office within 24 hours of receipt of the call

Provider communications

Provider website home page

Anthem BlueCross BlueShield

Nevada Providers

A- A A+

Login | Register

- Home
- Join Our Network
- Claims
- Precertification
- Medical
- Pharmacy
- Members
- Provider Education & Support
- Account Updates
- Find a Doctor
- Vendor Partners

News & Announcements

CAQH EnrollHub, which has been temporarily offline, will be operational on January 27, 2020.

Clinical Criteria Web Posting September 2019

On September 19, 2019, the Pharmacy and Therapeutics (P&T) Committee approved the following Clinical Criteria applicable to the medical drug benefit for Anthem Blue Cross. These policies were developed, revised or reviewed to support clinical coding edits. Clinical Criteria Web Posting September 2019

How to Contact IngenioRx Specialty Pharmacy beginning May 1, 2019

If you need to contact IngenioRx Specialty Pharmacy regarding a Medicaid member, please read our announcement for more information.

Shared decision-making aid available

As part of our commitment to provide the latest clinical information and improve member outcomes, we have posted a vaginal birth after cesarean guide. Read more.

New Amerigroup Community Care is now Anthem Blue Cross and Blue Shield Healthcare Solutions

Effective February 1, 2018, Amerigroup Community Care is now Anthem Blue Cross and Blue Shield Healthcare Solutions. To see what this means for you and our members, read more.

Useful Publications

Provider Communications & Updates ▶

Manuals, Directories, Training & More ▶

Useful Links:

- Nevada Division of Health Care Financing and Policy
- Office of Consumer Health Assistance

Fraud, waste and abuse referrals

Fraud, waste and abuse referrals can be made through the following avenues:

- Medicare/Medicaid Fraud Hotline **1-866-847-8247**
- Compliance and Ethics Hotline **1-877-660-7890**
- Member Fraud, Waste and Abuse **1-800-600-4441** medicaidfraud@anthem.com

Availability standards

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

Type of care	Standard
After-hours access	Members must have access to communicate with provider after hours. See the provider manual for details.
Medically necessary care	Same day
Urgent care	Two calendar days
Routine care	Two weeks (doesn’t apply to regular visits to monitor chronic condition if condition requires more frequent visits)

All providers are expected to meet the federal and state accessibility standards and those defined in the *Americans with Disabilities Act of 1990*. Health care 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.

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 he/she has 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
Medically necessary care	Same day (within 24 hours of referral)
Urgent care	Within three calendar days of referral
Routine	Within 30 calendar days of referral
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 or immediately if an emergency exists

Behavioral health providers must adhere to the following access guidelines:

Type of care	Standard
Care for nonlife-threatening emergency	Within six hours
Urgent care	Within 48 hours
Initial visit for routine appointment	Within 10 business days
Follow-up routine care	Within two weeks

Cultural competency

- Anthem expects providers and their staff to gain and continually increase their skills/knowledge around cultural competency and sensitivities to diverse cultures. Cultural competency includes:
  - Effective care and services for all people by taking into account each person's values, reality conditions and linguistic needs.
  - Removing cultural barriers in a health care setting.

- To view our cultural competency training and resources, visit our website at https://mediproviders.anthem.com/nv.

Key contacts

If you have questions or need help with any item, contact:

- Provider Services via the following:
  - **1-844-396-2330**
  - nv1provsvcs@anthem.com
- Your local Provider Relations representative.

Important phone numbers

Phone numbers and email contact

- Provider Services:
  - Telephone: **1-844-396-2330**
  - Fax: **1-800-964-3627**
  - Email: nv1provsvcs@anthem.com
- TTY: **711**
- Automated member eligibility: **1-844-396-2330**
- 24/7 NurseLine: **1-844-396-2329 (TTY 711)**
- Member Services: **1-844-396-2329 (TTY 711)**
- Pharmacy Services: **1-844-396-2330**
- EDI: **1-800-590-5745**

State of Nevada phone numbers

- DHCFP Nevada Medicaid office: **1-775-684-3600**
- DHCFP Nevada Check Up office: **1-775-684-3777**
- DXC: **1-877-638-3472**

Partner phone numbers

Vision services
- EyeQuest: **1-888-696-9551**

Radiology services
- AIM Specialty Health: **1-800-714-0040**

Nonemergency transportation
- MTM: **1-844-879-7341**

MTM is an independent company providing transportation services on behalf of Anthem Blue Cross and Blue Shield Healthcare Solutions.

Anthem Blue Cross and Blue Shield Healthcare Solutions
Medicaid Managed Care

https://mediproviders.anthem.com/nv
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