Anthem • New York | Essential Plan

Provider Manual

Anthem

NYBCBS-CD-PM-080253-25 April 2025

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April 2025

Provider Manual Table of Contents

1 INTRODUCTION

Welcome to the Anthem Blue Cross and Blue Shield HP (Anthem) network provider family. We're pleased you have joined the network, which represents some of the finest healthcare practitioners in the state of New York.

Anthem is offering a new comprehensive and affordable health insurance program. The Essential Plan is a health benefits coverage program for low-to-moderate-income residents who would otherwise be ineligible to purchase coverage through the Health Insurance Marketplace or qualify for Medicaid.

We are a licensed Health Maintenance Organization (HMO). We bring expertise, both locally and nationally, to operate local, community-based healthcare plans with experienced local staff to complement our operations. We are committed to assisting you in providing quality health care.
As an Anthem provider, your continued commitment to providing quality care across all products to our members is central to helping them achieve and maintain good health. We believe hospitals, physicians, and other providers play a pivotal role in managed care. We can only succeed by working collaboratively with you and other caregivers. Earning your loyalty and respect is essential to maintaining a stable, high-quality provider network.

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 prescheduled at times and locations intended to be convenient for you. Please call Provider Services at **800450-8753** with any suggestions, comments, or questions you may have. Together, we can arrange for and provide an integrated system of coordinated, efficient, and quality care for our members and your patients.

Please note this provider manual will be amended as our operational policies change. The plan will notify you by mail, phone, or email. If you believe you do not have the most current edition of our manual, please email us at nyproviderrequests@anthem.com to receive a new one.

2 OVERVIEW

Who is Anthem Blue Cross and Blue Shield HP?

Anthem Blue Cross and Blue Shield HP (Anthem) is a wholly owned subsidiary of Elevance Health. As a leader in managed healthcare services for the public sector, Anthem provides healthcare coverage exclusively to low-income families, seniors, and people with disabilities. Anthem is an award-winning Prepaid Health Service Plan (PHSP) that provides and manages government-sponsored health insurance programs to eligible members in the five boroughs of New York City as well as Nassau, Suffolk, Westchester, and Putnam counties. Currently, we provide the Essential Plans, Child Health Plus (CHPlus), Medicaid Managed Care (MMC), and Managed Long-Term Care (MLTC)/Medicaid Advantage Plus (MAP) services to over 440,000 members and are one of the largest health plans in New York City.

We're dedicated to improving the quality of life of each member by providing the best and most reliable health care to the communities we serve. Our extensive community outreach efforts were recognized by the American Association of Health Plans' Community Leadership Award.

Mission

Our mission is to operate a community-focused managed care company with an emphasis on the public sector healthcare market. We will coordinate members' physical and behavioral health care, offering a continuum of education, access, care, and outcome programs that we believe result in lower costs, improved quality, and better health statuses for these members.

Strategy

Our strategy is to:

- Improve access to preventive primary care services by ensuring the selection of a primary care provider who will serve as provider, care manager, and coordinator for all basic medical services.
- Educate members about their benefits and responsibilities and the appropriate use of healthcare services.
- Encourage stable, long-term relationships between providers and members.
- Discourage medically inappropriate 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.

Summary

Escalating health care 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.

QUICK REFERENCE INFORMATION

Please call Provider Services at the National Customer Care department 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.

Here is some information to help you in your day-to-day interaction with us.

Anthem phone numbers and websites

Provider Services Phone:	800-450-8753
Provider Services Fax:	800-964-3627
AT&T Relay Service:	711
Provider Website:	providers.anthem.com/ny
Member Eligibility:	800-450-8753
Precertification (Medical and Behavioral Health):	800-450-8753
Precertification Fax (Medical):	800-964-3627
Behavioral Health Precertification	Should be submitted electronically using our preferred method via Availity.com.
Case Management:	800-450-8753
Condition Care (CNDC):	888-830-4300
Electronic Data Interchange (EDI) Availity:	800-282-4548
24/7 NurseLine:	800-300-8181
Member Services:	800-300-8181
Pharmacy Services:	800-450-8753
Appeals Inquiry:	866-696-4701
Clinical Practice Guidelines:	800-450-8753
Report Fraud:	866-847-8247 or visit our fighthealthcarefraud.com education site; at the top of the page select

	Report it and complete the *Report Waste, Fraud and Abuse* form
Chief Compliance Officer:	**ethics@anthem.com**
Availity Training	Provider Learning Hub

Provider and Facility Digital Guidelines
Anthem understands that working together digitally streamlines processes and optimizes efficiency. We developed the Provider and Facility Digital Guidelines to outline our expectations and to fully inform providers and facilities about our digital platforms.

Anthem expects providers and facilities will utilize digital tools unless otherwise prohibited by law or other legal requirements.

Digital guidelines establish the standards for using secure digital Provider platforms (websites) and applications when transacting business with Anthem. These platforms and applications are accessible to both participating and nonparticipating providers and facilities and encompass Availity.com, electronic data interchange (EDI), electronic medical records (EMR) connections, and business-to-business (B2B) desktop integration.

The Digital Guidelines outline the digital/electronic platforms Anthem has available to participating and nonparticipating providers and facilities who serve its members. The expectation of Anthem is based on our contractual agreement that providers and facilities will use these digital platforms and applications unless otherwise mandated by law or other legal requirements.
Digital and/or electronic transaction applications are accessed through these platforms:

- Availity Essentials EDI Clearinghouse
- B2B application programming interfaces (APIs)
- EMR connections

Digital guidelines available through Availity Essentials include:

- Acceptance of digital ID cards
- Eligibility and benefits inquiry and response
- Prior authorization submissions including updates, clinical attachments, authorization status, and clinical appeals
- Claim submission, including attachments, claim status
- Remittances and payments
- Provider enrollment
- Demographic updates

Additional digital applications available to providers and facilities include:

- Pharmacy prior authorization drug requests

Services through Carelon Medical Benefits Management, Inc.
Services through Carelon Behavioral Health, Inc.

Anthem expects providers and facilities transacting any functions and processes above will use available digital and/or electronic self-service applications in lieu of manual channels (paper, mail, fax, call, chat, etc.). All channels are consistent with industry standards. All EDI transactions use version 5010.

Note: As a mandatory requirement, all trading partners must currently transmit directly to the Availity Essentials EDI gateway and have an active Availity Essentials Trading Partner Agreement in place. This includes providers using their practice management software & clearinghouse billing vendors.

Providers and facilities who do not transition to digital applications may experience delays when using non-digital methods such as mail, phone, and fax for transactions that can be conducted using digital applications.

Section 1: Accepting digital ID cards

As our members transition to digital member ID cards, providers and facilities may need to implement changes in their processes to accept this new format. Anthem expects that providers and facilities will accept the digital version of the member identification card in lieu of a physical card when presented. If providers and facilities require a copy of a physical ID card, members can email a copy of their digital card from their smartphone application, or providers and facilities may access it directly from Availity Essentials through the Eligibility and Benefits Inquiry application.

Section 2: Eligibility and benefits inquiry and response

Providers and facilities should leverage these Availity Clearinghouse hosted channels for electronic eligibility and benefit inquiry and response:

- EDI transaction: X12 270/271 – eligibility inquiry and response:
  - Anthem supports the industry-standard X12 270/271 transaction set for eligibility and benefit inquiry and response as mandated by HIPAA.
- Availity Essentials:
  - The Eligibility and Benefits Inquiry verification application allows a Provider and Facility 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 EMR software. Contact Availity Essentials for available vendor integration opportunities.

Section 3: Prior authorization submission, attachment, status, and clinical appeals.
Providers and facilities should leverage these channels for prior authorization submission, status inquiries and to submit electronic attachments related to prior authorization submissions:

- EDI transaction: X12 278 – prior authorization and referral:
  - 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 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.
- Availity Essentials:
  - Authorization applications include the Availity Essentials multi-payer Authorization and Referral application) for authorization submissions not accepted through Availity Essentials' multi-payer application.
    - Both applications enable prior authorization submission, authorization status inquiry, and the ability to review previously submitted authorizations.
- 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 EMR software. Contact Availity for available vendor integration.

Section 4: Claims: submissions, claims payment disputes, attachments, and status
Claim submissions status and claims payment disputes
Providers and facilities should leverage these channels for electronic claim submission, attachments (for both pre- and post-payment), and status:

- 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.
  - 837 Claim batch upload through EDI allows a provider to upload a batch/file of claims (must be in X12 837 standard format).
- EDI transaction: X12 276/277 – Claim status inquiry and response:
  - Anthem supports the industry-standard X12 276/277 transaction set for Claim status inquiry and response as mandated by HIPAA.
- Availity Essentials: The Claims & Payments application enables a provider to enter a Claim directly into an online Claim form and upload supporting documentation for a defined Claim.
  - Claim Status application enables a provider to access online Claim status. Access the Claim payment dispute tool from Claim Status. Claims Status also enables online

claim payment disputes in most markets and for most claims. It is the expectation of Anthem that electronic Claim payment disputes are adopted when and where it is integrated.

- 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 EMR software. Contact Availity for available vendor integration.

Claim attachments

Providers and facilities should leverage these channels for electronic Claim attachments from Availity.com:

- EDI transaction: X12 275 – Patient information, including HL7 payload attachment:
  - Anthem supports the industry standard X12 275 transaction for electronic transmission of supporting Claim documentation including medical records via the HL7 payload.

Availity Essentials – Claim Status application enables a provider or facility to digitally submit supporting claims documentation, including medical records, directly to the Claim.

- Digital Request for Additional Information (Digital RFAI) – The Medical Attachments application on Availity Essentials enables the transmission of digital notifications when additional documentation including medical records are needed to process a Claim.

Section 5: Electronic remittance advice and electronic claims payment

Electronic remittance advice:

- Electronic remittance advice (ERA) is an electronic data interchange (EDI) transaction of the explanation of payment of your claims. Anthem supports the industry-standard X12 835 transaction as mandated per HIPAA.
- Providers and facilities can register, enroll, and manage ERA preference through Availity.com. Printing and mailing remittances will automatically stop thirty (30) days after the ERA enrollment date.
  - Viewing an ERA on Availity Essentials is under Claims & Payments, Remittance Viewer. Features of remittance viewer, include the ability to search a two (2) year history of remittances and access the paper image.
  - Viewing a portable document format (PDF) version of a remit is under Payer Spaces which provides a downloadable PDF of the remittance.

To stop receiving ERAs for your claims, contact Availity Client Services at **800-AVAILITY** (**282-4548**).

To re-enable receiving paper remittances, contact Provider Services.

Electronic claims payment

Electronic claims payment is a secure and fast way to receive payment, reducing administrative processes. There are several options to receive claims payments electronically:

- Electronic Funds Transfer (EFT):
  - Electronic funds transfer (EFT) uses the automated clearinghouse (ACH) network to transmit healthcare payments from a health plan to a provider's or facility's bank account at no charge for the deposit. Health plans can use a provider's or facility's banking information only to deposit funds, not to withdraw funds. The EFT deposit is assigned a trace number (TRN) to help match the payment to the correct 835 electronic remittance advice (ERA), a process called reassociation.
  - **To enroll in EFT:** Providers and facilities can register, enroll, and manage account changes for EFT through EnrollSafe at enrollsafe.payeehub.org. EnrollSafe enrollment eliminates the need for paper registration. EFT payments are deposited faster and are generally the lowest cost payment method. For help with enrollment, use this convenient EnrollSafe User Reference Manual.
  - **To disenroll from EFT:** Providers and facilities are entitled to disenroll from EFT. Disenroll from EFT payments through EnrollSafe at enrollsafe.payeehub.org.
- Virtual Credit Card (VCC):
  - For providers and facilities who don't enroll in EFT, and in lieu of paper checks, Anthem is shifting some reimbursements to virtual credit cards (VCC). VCC allows providers and facilities to process payments as credit card transactions. Check with your merchant processor regarding standard transaction fees that will apply.
  - Note that Anthem may receive revenue for issuing a VCC.
  - **Opting out of virtual credit card payment**. Providers and facilities are entitled to opt out of electronic payment. To opt out of virtual credit card payment, there are two options:
    - Enrolling for EFT payments automatically opts you out of virtual credit card payments. To receive EFT payments instead of virtual credit card payments, enroll for EFT through EnrollSafe at enrollsafe.payeehub.org.
      OR
    - To opt out of virtual credit card payments, contact Comdata at **800-833-7130** and provide your taxpayer identification number.
- Zelis Payment Network (ZPN) electronic payment and remittance combination
  - The Zelis Payment Network (ZPN) is an option for providers and facilities looking for the additional services Zelis can offer. Electronic payment (ACH or VCC) and Electronic Remittance Advice (ERA) via the Zelis portal are included together with additional services. For more information, go to Zelis.com. Zelis may charge fees for their services.
  - Note that Anthem may receive revenue for issuing ZPN.
  - ERA through Availity is not available for providers and facilities using ZPN.
  - **To disenroll from ZPN payment,** there are two options:

- Enrolling for EFT payments automatically removes you from ZPN payments. To receive EFT payments instead of ZPN payments, enroll for EFT through EnrollSafe at enrollsafe.payeehub.org.
  OR
- To disenroll from ZPN payments, update your Zelis registration on the Zelis provider portal or contact Zelis at **877-828-8770**.

Not being enrolled for EFT, VCC, or ZPN will result in paper checks being mailed.

Important Anthem Addresses
Claims Information
Submit Electronic Claims (EDI) to Availity:

- Electronic claims payer IDs:
- Professional - 00803
- Institutional - 00303

Submit paper claims to:

Anthem Blue Cross and Blue Shield HP
P.O. Box 61010
Virginia Beach, VA 23466-1020

Provider Complaints
Provider complaints should be submitted to:

Anthem Blue Cross and Blue Shield HP
Attn: Provider Relations
PENN 1, 35th Fl
New York, NY 10119
Email: nyproviderinquiries@anthem.com

Medical Appeal Information
Medical appeals must be filed within 180 calendar days of the date of the notice of action.
File a standard medical appeal at:

Anthem Blue Cross and Blue Shield HP
Medical Appeals
P.O. Box 62429
Virginia Beach, VA 23466-2429

Fax an **Expedited Appeal only** to **866-495-8716**.

Other Contact Information
Superior Vision (Vision and Ophthalmology Medical Services):

- Member Services Line: **800-879-6901**

- Provider Services Line: **866-819-4298**
- Website: SuperiorVision.com

Liberty Dental Plan (Dental Services):

- Member Services Line: **833-276-0847**
- Provider Services Line: 833-276-0853
- Website: libertydentalplan.com

Carelon Medical Benefits Management, Inc. (Radiology, Cardiology Studies, Genetic Testing, Sleep Study, Outpatient Rehab (PT/OT/ST), Musculoskeletal (MSK) and Pain and Spine management Services):

- Providers: **800-714-0040**:
  - Hours of operation: Monday-Friday 7 a.m. to 7 p.m. Central time
- Provider portal: providerportal.com

ASH (Chiropractic Services and Precertification):

- Provider Services: **800-972-4226:**
  - Hours of operation: Monday-Friday 7 a.m. to 9 p.m. Eastern time
- Address:

American Specialty Health
PO Box 509001
San Diego, CA 92150-9001

Providers should submit ASH Clinical Treatment Forms (Authorizations) by fax to **877-304-2746**

- Providers can obtain ASH's Clinical Treatment Forms by visiting ASHLink.com
- Out-of-network provider packets can be found by selecting on **Resources** > **Providers** > **Chiropractic** > **Nonparticipating Practitioner Claims Packet**

New York State Department of Health:

- Phone: **800-206-8125**
- Website: health.ny.gov

Our Website

Our website contains a full complement of resources, including inquiry tools for real-time eligibility, claims status, and referral authorization status. In addition, the website provides general information you'll find helpful, such as: forms; the Preferred Drug List (PDL); 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 better with us. Visit providers.anthem.com/ny to learn more.

If you are unable to access the internet, you may receive claims status, eligibility verification, and authorization status over the telephone at any time by calling our toll-free, automated Provider Inquiry Line at **800-450-8753**.

Ongoing Provider Communications

To ensure you're up-to-date with the information required to work effectively with us and our members, we periodically send you broadcast faxes, provider manual updates, and newsletters, as well as post information on our website. Every other month, we will post a Network Update newsletter to provide a one-stop resource for important Anthem news.

3 ESSENTIAL PLAN MEMBER ELIGIBILITY

Member Identification Cards

Our members are given identification (ID) cards identifying them as participants in our program within 14 calendar days of the effective dates of enrollment with us. To ensure immediate access to services, you must accept members' Essential Plan ID cards or the Anthem temporary member ID cards as proof of enrollment in Anthem until they receive Anthem member ID cards. The holder of the Anthem member ID card should be the member or the guardian of the member. The ID card will include:

- The member's ID and Group number

The member's name (first name, last name and middle initial)

- The member's date of birth
- The member's enrollment effective date
- Toll-free phone numbers for information and/or authorizations

Toll-free Nurse HelpLine, available 24 hours a day, 7 days a week

- Descriptions of procedures to be followed for emergency or special services
- Anthem address and telephone number
- PCP name and telephone number

ID cards should be treated the same as you would treat the original plastic card. Remember to verify eligibility through our website at every visit, no matter which type of card a member presents.

Essential Plan Member ID Card

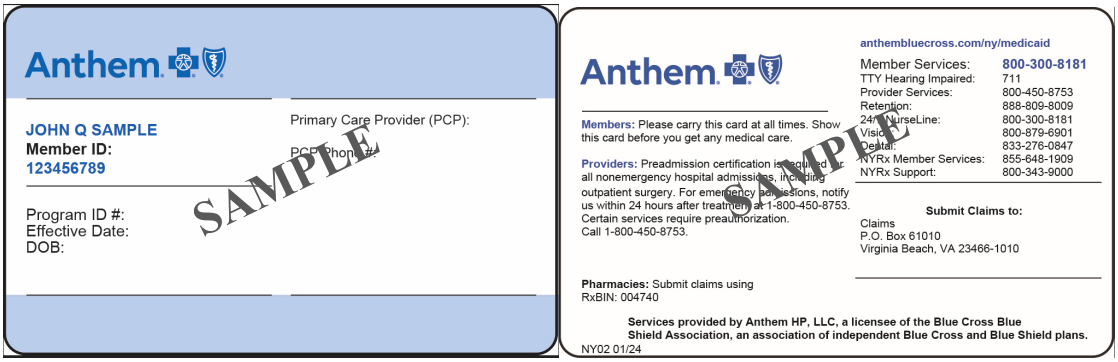
Upon enrollment in the Anthem Blue Cross and Blue Shield HP Essential Plan, members will receive a plan ID card. Members in Plans 3 and 4 will also receive a NY State Benefits Card (CBIC) to access additional services. Consumers have the option of using either the Essential Plan ID card or the CBIC.

The group number field on our ID card identifies members enrolled in the Essential Plan. The following chart should be used to identify and reference the Essential Plan group numbers:

Plan	Prefix	Group Number
Essential Plan 1	JLJ	54 & 55
Essential Plan 2	JLJ	52 & 53
Essential Plan 3	JLJ	51
Essential Plan 4	JLJ	50

Sample Anthem Essential Plan member cards

Sample member ID card



The health plan name and important phone numbers are on the back of each card for easy reference.

Member Enrollment

Member enrollment in Anthem is voluntary. Members who meet the state's eligibility requirements for participation are eligible to join the Essential Plan through our health care plan. Eligible members are enrolled without regard to health status.

Member Disenrollment

A member can be disenrolled from the health plan in limited circumstances. If you believe a member should be disenrolled for a medical reason or for noncompliance, please contact Member Services at **800-300-8181** for assistance. **Note: The Essential Plan is a voluntary program. A member may choose to disenroll from Anthem at any time.**

Member Eligibility Listing

You should verify each member receiving treatment in your office actually appears on your membership listing. Accessing your panel membership listing via our provider website is the most accurate way to determine member eligibility. You will have secure access to an electronic listing of your panel of assigned members, once registered and logged in to providers.anthem.com/ny.

To request a hard copy of your panel listing be mailed to you, call Provider Services at **800-450-8753**.

4 ESSENTIAL PLAN BENEFITS AND COST-SHARING

Essential Plan — Four Options

There are four Essential Plan options. Enrollment in each Essential Plan is dependent on an individual's Federal Poverty Level (FPL) and immigration status. Coverage varies between the four plan options.

All Essential Plans (Essential Plans 1-4) offer comprehensive services known as *essential health benefits* and include the following categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn
- Mental health and substance use disorder services, including:
- Behavioral health treatment
- Rehabilitative and habilitative services and devices
- Prescription drugs
- Laboratory services
- Preventive and wellness and chronic disease management

Essential Plans 1 and 2 offer a vision and dental option in addition to the essential health benefits noted above.

Essential Plans 3 and 4 offer the following additional services:

- Nonemergency transportation
- Nonprescription drugs
- Adult dental care
- Vision care
- Orthotic services
- Orthopedic footwear

All services and benefits are subject to plan provisions and must be medically necessary. Services other than primary care, obstetrics/gynecology (OB-GYN), and mental health/substance abuse may require precertification. Details about which services require precertification can be found in **Chapter 6 – Prior Authorization** and Grid or by using the **Precertification Lookup Tool** located on our website.

Cost Sharing

Use the cost-sharing grid below to view the differences in cost-sharing between the four Essential Plans.

Anthem Essential Plan Cost Sharing				
Cost Sharing	Essential Plan 1	Essential Plan 2	Essential Plan 3	Essential Plan 4
Out-of-pocket limit	$2,000	$200	$200	$0
Primary care office visits	$15	$0	$0	$0
Specialist office visits (or home visits)	$25	$0	$0	$0
Screening for prostate cancer				
• Performed in PCP office	$15	$0	$0	$0
• Performed in specialist office	$25	$0	$0	$0
Prehospital emergency medical services (ambulance services)	$75	$0	$0	$0
Nonemergency ambulance services	$75	$0	$0	$0
Emergency department Copayment/coinsurance waived if hospital admission	$75	$0	$0	$0
Urgent care center	$25	$0	$0	$0
Advanced imaging services				
• Performed in a freestanding radiology facility or office setting	$25	$0	$0	$0
• Performed as outpatient hospital services	$25	$0	$0	$0
Allergy testing and treatment				
• Performed in a PCP office	$15	$0	$0	$0
• Performed in a specialist office	$25	$0	$0	$0
Ambulatory surgical center facility fee	$50	$0	$0	$0
Cardiac and pulmonary rehabilitation				
• Performed in a specialist office	$25	$0	$0	$0
• Performed as outpatient hospital services	$25	$0	$0	$0

Anthem Essential Plan Cost Sharing				
Cost Sharing	Essential Plan 1	Essential Plan 2	Essential Plan 3	Essential Plan 4
• Performed as inpatient hospital services	Included as part of inpatient hospital service cost-sharing			
Chemotherapy				
• Performed in a PCP office	$15	$0	$0	$0
• Performed in a specialist office	$15	$0	$0	$0
• Performed as outpatient hospital services	$15	$0	$0	$0
Chiropractic services	$25	$0	$0	$0
Diagnostic testing				
• Performed in a PCP office	$15	$0	$0	$0
• Performed in a specialist office	$25	$0	$0	$0
• Performed as outpatient hospital services	$25	$0	$0	$0
Dialysis				
• Performed in a PCP office	$15	$0	$0	$0
• Performed in a freestanding center or specialist office setting	$15	$0	$0	$0
• Performed as outpatient hospital services	$15	$0	$0	$0
Habilitation services (Physical therapy, occupational therapy, or speech therapy) 60 visits per condition, per lifetime combined therapies	$15	$0	$0	$0
Home health care – 40 visits per plan year	$15	$0	$0	$0
Infusion therapy				
• Performed in a PCP office	$15	$0	$0	$0

Anthem Essential Plan Cost Sharing				
Cost Sharing	**Essential Plan 1**	**Essential Plan 2**	**Essential Plan 3**	**Essential Plan 4**
• Performed in specialist office	$15	$0	$0	$0
• Performed as outpatient hospital services	$15	$0	$0	$0
• Home infusion therapy (home infusion counts toward home health care visit limits)	$15	$0	$0	$0
Laboratory procedures				
• Performed in a PCP office	$15	$0	$0	$0
• Performed in a freestanding laboratory facility or specialist office	$25	$0	$0	$0
• Performed as outpatient hospital services	$25	$0	$0	$0
Maternity				
• Prenatal care	$0	$0	$0	$0
• Inpatient hospital services and birthing center	$150 per admission	$0	$0	$0
• Physician and midwife services for delivery	$50	$0	$0	$0
• Breast pump	$0	$0	$0	$0
• Postnatal care	Included in physician and midwife services for delivery cost-sharing	Included in physician and midwife services for delivery cost-sharing	Included in physician and midwife services for delivery cost-sharing	Included in physician and midwife services for delivery cost-sharing
Outpatient hospital surgery facility charge	$50	$0	$0	$0

Anthem Essential Plan Cost Sharing				
Cost Sharing	Essential Plan 1	Essential Plan 2	Essential Plan 3	Essential Plan 4
Diagnostic radiology services				
• Performed in a PCP office	$15	$0	$0	$0
• Performed in a freestanding radiology facility or specialist office	$25	$0	$0	$0
• Performed as outpatient hospital services	$25	$0	$0	$0
Outpatient hospital surgery facility charge	$50	$0	$0	$0
Diagnostic radiology services				
• Performed in a PCP office	$15	$0	$0	$0
• Performed in a freestanding radiology facility or specialist office	$25	$0	$0	$0
• Performed as outpatient hospital services	$50	$0	$0	$0
Therapeutic radiology services				
• Performed in a freestanding radiology facility or specialist office	$15	$0	$0	$0
• Performed as outpatient hospital services	$15	$0	$0	$0
Rehabilitation services (physical therapy, occupational therapy, or speech therapy) (60 visits per condition, per lifetime; per plan year combined therapies)	$15	$0	$0	$0
Second opinions on the diagnosis of cancer, surgery, and other	$25	$0	$0	$0
Surgical services (including oral surgery; reconstructive breast surgery; other reconstructive and corrective surgery; transplants; and interruption of pregnancy)	$150	$0	$0	$0

Anthem Essential Plan Cost Sharing				
Cost Sharing	Essential Plan 1	Essential Plan 2	Essential Plan 3	Essential Plan 4
All transplants must be performed at designated facilities.				
• Inpatient hospital surgery	$50	$0	$0	$0
• Outpatient hospital surgery	$50	$0	$0	$0
• Surgery performed at an ambulatory surgical center	$15 (when performed at PCP office)	$0	$0	$0
• Office surgery	$25 (when performed at specialist office)	$0	$0	$0
Telemedicine program	$15 PCP visit $25 specialist visit	$0	$0	$0
ABA treatment for Autism Spectrum Disorder	$15	$0	$0	$0
Assistive communication devices for Autism Spectrum Disorder	$15	$0	$0	$0
Durable medical equipment and braces	5% cost-sharing	$0	$0	$0
External hearing aids (Single purchase; one every three years)	5% cost-sharing	$0	$0	$0
Cochlear implants (One per ear per time covered)	5% cost-sharing	$0	$0	$0
Hospice care				
• Inpatient	$150	$0	$0	$0
• Outpatient	$15	$0	$0	$0

Anthem Essential Plan Cost Sharing				
Cost Sharing	Essential Plan 1	Essential Plan 2	Essential Plan 3	Essential Plan 4
• 210 days per plan year				
Medical supplies	5% coinsurance	$0	$0	$0
Prosthetic devices				
• External • One prosthetic device, per limb, per lifetime, and the cost of repair and replacement of the prosthetic devices and their parts	5% coinsurance	$0	$0	$0
• Internal	Included as part of inpatient hospital cost-sharing	$0	$0	$0
Inpatient hospital for a continuous confinement (including an inpatient stay for mastectomy care, cardiac and pulmonary rehabilitation, and end of life care)	$150	$0	$0	$0
Observation stay Copay waived if direct transfer from outpatient surgery setting to observation	$75	$0	$0	$0
Skilled nursing facility (including cardiac and pulmonary rehabilitation) 200 days per plan year Copay waived for each admission if directly transferred from hospital inpatient setting to skilled nursing facility	$150 **PA; Referral required**	$0	$0	$0
Inpatient rehabilitation services	$150	$0	$0	$0

Anthem Essential Plan Cost Sharing				
Cost Sharing	Essential Plan 1	Essential Plan 2	Essential Plan 3	Essential Plan 4
(Physical, speech and occupational therapy) 60 consecutive days per condition, per lifetime	**PA; Referral required**			
Inpatient mental health care (for a continuous confinement when in a hospital)	$150 **PA; Notification within 2 BD required**	$0	$0	$0
Outpatient mental health care (including partial hospitalization and intensive outpatient program services)	$15	$0	$0	$0
Inpatient substance use services (for a continuous confinement when in a hospital)	$150 **PA; Notification within 2 BD required**	$0	$0	$0
Outpatient substance use services	$15	$0	$0	$0

Physician Services

Physician services include the full range of preventive, primary care medical services and physician specialty services that fall within a licensed physician's scope of practice under New York State (NYS) law. Physician's assistants' services are included within the scope of physician services, as they act as extenders to physician services.

In addition to the full range of medical services, the following benefits are also included: Certain specified laboratory procedures performed in the office during the course of treatment (refer to laboratory services) Family planning health services including diagnosis, treatment and related counseling furnished under the supervision of a physician (limited fertility services are covered).

Preventive Care

We cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to cost-sharing (copays or coinsurance) when performed by a participating provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA), or if the items or services have an “A” or “B” rating from the United States Preventive Services Task Force (USPSTF), or if the immunizations are recommended by the Advisory Committee on Immunization Practices (ACIP).

Second Opinion Services

Members may be referred to other providers for second opinions within our provider network, for diagnosis of a condition, treatment and surgical procedures.

Gynecological Care Services

Gynecological services may be accessed by all female members without a PCP referral. Covered services include one routine examination per member annually, treatment of all acute gynecological conditions, and follow-up treatment visits.

Inpatient Hospital Care

Inpatient stay pending alternate level of medical care means continued care in a hospital pending placement in an alternative lower medical level of care, consistent with provisions of 18 NYCRR 505.20 and 10 NYCRR, Part 85.

Acute care in a general hospital is covered up to 365 days a year, encompassing a full range of necessary diagnostic and therapeutic care, including surgical, medical, nursing, radiological, and rehabilitative services. Precertification is required for inpatient hospital care.

Inpatient Stay for Maternity Care

We cover inpatient maternity care in a hospital for the mother, and inpatient newborn care in a hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is medically necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also cover any additional days of such care that we determine are medically necessary. In the event the mother elects to leave the hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum coverage period, we will cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or at the time of the mother's request, whichever is later. Our coverage of this home care visit shall be in addition to home health care visits under this contract and shall not be subject to any cost-sharing amounts in the Schedule of Benefits section of this contract that apply to home care benefits.

New Baby, New Life℠

New Baby, New Life is a proactive case management program for all perinatal members and their newborns. We use several resources to identify pregnancies as early as possible. Sources of identification include state enrollment files, claims data, and hospital census reports 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 management services to mitigate risk.

Experienced care managers work with members and providers to establish a care plan for our highest risk pregnant members. Care 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 program which offers:

- Individualized, one-on-one complex care management support for members with the highest risk
- Care coordination for members who may need just a little extra support
- Digital perinatal educational tools
- Information on community resources
- Incentives to encourage members to keep up with checkups
- Proactive care coordination and complex care management support for parents of infants that are admitted to the neonatal intensive care unit (NICU)

As part of the New Baby, New Life program, perinatal members have access to a digital perinatal offering. This digital offering is available by smartphone app and provides pregnant and postpartum members with timely, proactive, and culturally appropriate education. 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 us to assess their pregnancy risk.

After the risk assessment has been completed, the app delivers gestational-age appropriate education directly to the member. This digital offering does not replace the high-touch, individual care management approach for our highest risk pregnant members; however, it does serve as a supplemental 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 us to identify members who experience a change in risk acuity throughout the perinatal period.

We request 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 Essentials or fax the completed forms to **1-800-964-3627**.

We also ask that providers complete the Maternity Application in Availity Essentials during the initial E&B request performed on a pregnant member. The information obtained during this process supports our effort to identify pregnancies as early as possible so that we may notify eligible members of various perinatal resources, including the care management program. The steps to complete the Maternity Application are detailed below:

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.**
- **If the appropriate conditions apply for payer, user, member and service type, the maternity question screen will display. Conditions include:**
    - **Member is female**
    - **Member is 45 years of age or under**
    - **Member is 15 years of age or over**
- **If member is not pregnant, select no and hit submit to continue to the E&B response screen.**
- **If member is pregnant, select yes and hit submit. You will be prompted to enter additional dates if known:**
    - **Estimated Due Date**
    - **First Prenatal Appointment Date**
- **When YES is selected, maternity data entered is saved for this member.**
- **After submitting your answer, the E&B response screen will display.**

We encourage healthcare providers to share information about this program and the digital perinatal app 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 Provider Services at **800-450-8753**, or refer to our website at providers.anthem.com/new-york-provider/patient-care/pregnancy-and-maternal-child-services.

NICU Case Management

If a baby is born premature or with a serious health condition, they may be admitted to the NICU. We believe the more parents know, the better they will be able to care for their infant. To support them, we have a NICU care management program.

We extend our support by helping parents to prepare themselves and their homes for when baby is released from the hospital. After baby is home, our care managers continue to provide education and assistance in improving baby's health, preventing unnecessary hospital readmissions, and guiding parents to community resources if needed.

The NICU can be a stressful place, bringing unique challenges and concerns that parents may have never imagined. The anxiety and stress related to having a baby in the NICU can potentially lead to symptoms of post-traumatic stress disorder (PTSD) in parents and caregivers. To reduce the impact of PTSD among our members, we assist by:

- Helping parents engage with hospital-based support programs
- Facilitating parent screenings for potential PTSD
- Connecting parents with behavioral health program resources and community support as needed
- Actively asking for their feedback on the provided resources and how an increased awareness of PTSD has helped

For more information about our NICU Case Management program, reach out to Provider Services at **800-450-8753**, or refer to our website at providers.anthem.com/new-york-provider/patient-care/pregnancy-and-maternal-child-services.

Outpatient Hospital Services

Outpatient hospital services are provided through ambulatory care facilities. Ambulatory care facilities include diagnostic and treatment centers, hospital outpatient departments, and emergency rooms. These facilities may provide those necessary medical, surgical, and rehabilitative services and items authorized by their operating certificates. Outpatient services (clinics) also include mental health, chemical dependency, alcohol, C/THP, and family planning services provided by ambulatory care facilities.

Emergency Services

Emergency services coverage includes services 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 physical or behavioral 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 the absence of immediate medical attention to result in the following:

- Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a pregnant woman, the health of the woman or her unborn child or, in the case of a behavioral condition, placing the health of the person or others in serious jeopardy
- Serious impairment to such person's bodily functions
- Serious dysfunction of any bodily organ or part of such person
- Serious disfigurement of such person

Members do not need to call their PCP or Anthem before seeking emergency care. Members can access the nearest emergency room regardless of location or network participation. Precertification is not required for services in a medical or behavioral health emergency. Access to emergency services is not restricted, and emergency services may be obtained from nonparticipating providers without penalty. Members are required to notify us or their PCP within 48 hours after receiving emergency care and to obtain precertification for any follow-up care delivered pursuant to the emergency. Nothing in this provider manual or policies and procedures precludes us from entering into contracts with providers or facilities that require providers or facilities to provide notification to us after members present for emergency services and are subsequently stabilized.

Home Health Services

Home health services encompass services provided by a certified home health care agency in the member's home and include therapeutic and preventive nursing, home health aides, medical supplies, equipment and appliances, rehabilitative therapies (physical, occupational and speech), social work services or nutritional services.

Nurse Practitioner Services

The practice of a nurse practitioner may include preventive services, the diagnosis of illness and physical conditions and the performance of therapeutic and corrective measures. A nurse practitioner must have a collaborative agreement and practice protocols with a licensed physician in accordance with the requirements of the NYS Department of Education. A certified nurse practitioner may be used as a PCP.

Wellness Programs

Anthem will partially reimburse members for certain exercise facility fees or membership fees:

- Exercise facility fees or membership fees, but only if such fees are paid to exercise facilities in agreement with and which maintain equipment and programs that promote cardiovascular wellness
- An eligible exercise facility must have at least two pieces of equipment or activities that promote cardiovascular wellness
- Exercise classes (e.g., yoga, pilates, spinning)

For member to be eligible for reimbursement, they must:

- Be an active member of the exercise facility or attend classes at the exercise facility
- Complete 50 visits in a six-month period

Memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be reimbursed. Lifetime memberships are not eligible for reimbursement. Reimbursement is limited to actual workout visits. We will not provide reimbursement for equipment, clothing, vitamins or other services that may be offered by the facility (e.g., massages, etc.).

Laboratory Services

We are bound by the *Clinical Laboratory Improvement Amendments* (*CLIA*) of 1988. The purpose of the CLIA program is to ensure laboratories testing specimens in interstate commerce consistently provide accurate procedures and services. As a result of *CLIA*, any laboratory soliciting or accepting specimens in interstate commerce for laboratory testing is required to hold a valid license or letter of exemption from licensure.

Claims that are submitted for laboratory services subject to the *Clinical Laboratory Improvement Amendments* of *1988 (CLIA)* statute and regulations require additional information to be considered for payment.

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

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

To be considered for reimbursement of reference laboratory services, the referring laboratory must be an independent clinical laboratory. Modifier 90 must be submitted to

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

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

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

Vision Care

When applicable, optometry services are provided by Superior Vision. For a list of Superior Vision participating providers, please contact **877-235-5317** or visit SuperiorVision.com. The vision benefit allows for an exam by a participating optometrist once every 12 months or as medically necessary. Standard eyeglasses or contacts may be obtained once every year or as medically necessary when the optometrist prescribes them for the member. Our members can pay as private customers for nonstandard lenses, which are not covered. Members are financially responsible for upgrades of frames and/or lenses that are not medically necessary (e.g., personal preference upgrades).

Routine Dental Services

When applicable, dental care is handled through Liberty Dental Plan. Liberty Dental Plan will assign your patient to a primary care dentist who will be responsible for all of their general dental needs. This includes checkups, cleanings, routine fillings, extractions, orthodontia, and referrals for necessary specialty care. For benefit information, contact the Liberty Dental Plan at **833-276-0847** or visit libertydentalplan.com.

Non-Routine Dental Services

We cover care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services section(s) of the Essential Plan contract.

Behavioral Health Services

Please refer to the Preauthorization section of this contract for visit limits and any preauthorization requirements that apply to these benefits.

Mental Health Care Services

Inpatient Services

We cover inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders comparable to other similar hospital, medical and surgical coverage provided under this contract. Coverage for inpatient services for mental health care is limited to facilities defined in New York Mental Hygiene Law Section 1.03(10), such as:

A psychiatric center or inpatient facility under the jurisdiction of the New York State Office of Mental Health

- A state or local government run psychiatric inpatient facility
- A part of a hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health
- A comprehensive psychiatric emergency program or other facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health

We also cover inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders received at facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to Article 27-J of the New York Public Health Law; and, in other states, to facilities that are licensed or certified to provide the same level of treatment.

Outpatient Services

We cover outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Coverage for outpatient services for mental health care includes facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the New York State Office of Mental Health and, in other states, to similarly licensed or certified facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker who has at least three (3) years of additional experience in psychotherapy; a licensed mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst; or a professional corporation or a university faculty practice corporation thereof.

Limitations/Terms of Coverage

We do not cover:

Benefits or services deemed to be cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs

- Mental health benefits or services for individuals who are incarcerated, confined, or committed to a local correctional facility or prison
- Services solely because they are ordered by a court

Substance Use Services

Inpatient Services

We cover inpatient substance use services relating to the diagnosis and treatment of substance use disorder. This includes coverage for detoxification and rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance use services are limited to facilities in New York State, which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS); and, in other states, to those facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

We also cover inpatient substance use services relating to the diagnosis and treatment of substance use disorder received at facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to OASAS-certified facilities that provide services defined in 14 NYCRR 819.2(a)(1) and Part 817; and, in other states, to those facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

Outpatient Services

We cover outpatient substance use services relating to the diagnosis and treatment substance use disorder, including methadone treatment. Such coverage is limited to facilities in New York State that are certified by OASAS or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs, and, in other states, to those that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

Comprehensive Psychiatric Emergency Program (CPEP)

This licensed, hospital-based psychiatric emergency program establishes a primary entry point to the mental health system for individuals who may be mentally ill to receive emergency observation, evaluation, care, and treatment in a safe and comfortable environment. Emergency visit services include provision of triage and screening, assessment,

treatment, stabilization, and referral or diversion to an appropriate program. Brief emergency visits require a psychiatric diagnostic examination and may result in further CPEP evaluation or treatment activities, or discharge from the CPEP program. Full emergency visits, which result in a CPEP admission and treatment plan, must include a psychiatric diagnostic examination, psychosocial assessment and medication examination. Brief and full emergency visit services are reimbursable through the Essential Plan.

The following services do not require prior authorization:
Emergency room (ER) services, crisis services and a comprehensive psychiatric emergency program (CPEP); while there is no medical necessity review completed for ER or CPEP, providers are encouraged to notify Anthem to assist with discharge planning.

- Initial assessments and outpatient clinic services
- Outpatient mental health (OMH) and substance use disorder (SUD) services

Note: For opioid treatment (methadone maintenance), only notification is required.

Partial Hospitalization
A partial hospitalization program shall provide active treatment designed to stabilize and ameliorate acute symptoms, to serve as an alternative to inpatient hospitalization, or to reduce the length of a hospital stay within a medically supervised program. A partial hospitalization program shall provide the following services: assessment and treatment planning, health screening and referral, symptom management, medication therapy, medication education, verbal therapy, case management, psychiatric rehabilitation readiness determination and referral, crisis intervention services, activity therapy, discharge planning, and clinical support services.

Outpatient Mental Health
Periodic visits to a psychiatrist or other behavioral health practitioner for consultation in their office, or at a community-based outpatient clinic for mental health treatment.

Outpatient Drug and Alcohol (D&A)
Outpatient Drug and Alcohol services assist individuals who suffer from chemical abuse or dependence and their family members and/or significant others. D&A includes outpatient rehabilitation services, which are designed to serve individuals with more chronic conditions who have inadequate support systems, and either have substantial deficits in functional skills or have health care needs requiring attention or monitoring by health care staff.

Medically Supervised Outpatient Withdrawal
Outpatient SUD services (OASAS BH solo/group practice): Outpatient services include participant-centered services consistent with the individual's assessed treatment needs with a rehabilitation and recovery focus designed to promote skills for coping with and managing symptoms and behaviors associated with substance use disorders. These services

are designed to help individuals achieve and maintain recovery from SUDs. Services should address an individual's major lifestyle, attitudinal, and behavioral problems that have the potential to undermine the goals of treatment. Outpatient services are delivered on an individual, family or group basis in a wide variety of settings including site-based facility, in the community or in the individual's place of residence.

- These services may be provided on site or on a mobile basis as defined by the New York State Office of Alcoholism and Substance Abuse Services (OASAS).

Opioid treatment program (OPT) – methadone maintenance: OTPs are federally regulated programs that include direct administration of daily medication (opioid agonists: methadone or buprenorphine or antagonists following a successful agonist taper: naltrexone and injectable (Vivitrol) as well as a highly structured psychosocial program that addresses major lifestyle, attitudinal, and behavioral issues that could undermine recovery-oriented goals. The participant does not have a prescription for the methadone or buprenorphine, but receives daily medication from the OTP.

Rehabilitation Services for Residential SUD Treatment Supports (OASAS Service)
In this setting, medical staff is available in the residence; however, it is not staffed with 24 hour medical/nursing services. This setting provides medical and clinical services including: medical evaluation, ongoing medication management and limited medical intervention, medication-assisted substance use treatment when medically necessary, psychiatric evaluation and ongoing management, group, individual and family counseling focused on rehabilitation and increasing coping skills until the patient is able to manage feelings, urges and cravings, co-occurring psychiatric symptoms and medical conditions within the community. The treatment includes at least 30 hours of structured treatment of which at least 10 hours are individual, group or family counseling. Programs are characterized by their reliance on the treatment community as a therapeutic agent. It is also to promote abstinence from substance use and interpersonal behaviors to effect a global change in participants' lifestyles, attitudes, and values. Individuals typically have multiple functional deficits, which may include substance-related disorders, criminal activity, psychological problems, impaired functioning, and disaffiliation from mainstream values. Alcohol and Drug Treatment Referral (LOCADTR) criteria are used to determine level of care (LOC).

Pharmacy Services
Our pharmacy benefit covers medically necessary medications from licensed prescribers for the purpose of maintaining members' whole health, including saving lives in emergencies or during short-term illness, sustaining life in chronic or long-term illness, or limiting the need for hospitalization. Please note certain medications require prior authorization. Our members have access to national pharmacy chains and many independent retail pharmacies in the five boroughs of New York City, Nassau, Putnam, and the rest of the state. Our Pharmacy network includes major chains such as CVS, Target, Costco and ShopRite, as well as most independently owned pharmacies. We have contracted with CarelonRx as our pharmacy benefits manager (PBM) for Essential Plan members. Essential Plan members must use an

Anthem network pharmacy when filling prescriptions in order for benefits to be covered. For specialty drugs, please refer to the Specialty Drug Program section below.

Monthly Limits
All prescriptions are limited to a maximum 30-day supply per fill at retail, with the exception of asthma controller medications. Members may fill a prescription for a maximum of a 90-day supply at in-network mail-order pharmacies.

Covered Drugs
Our pharmacy program uses a Preferred Drug List (PDL), a list of preferred drugs within the most commonly prescribed therapeutic categories. Anthem's Pharmacy and Therapeutic (P&T) Committee developed the Prescription Drug Formulary. The Committee is composed of independent physicians from various medical specialties and clinical pharmacists who review the drugs in all therapeutic categories based on safety, efficacy and cost. The Committee will regularly review new and existing drugs to ensure the formulary remains responsive to the needs of our members and providers.
Anthem's formulary covers thousands of drugs. Our P&T Committee regularly reviews it to ensure we are providing the broadest coverage possible to meet our members' and physicians' need. You can now access the formulary online. Register or log in to Physician Online Services at providers.anthem.com/ny and select Pharmacy Information under Resources to access the most up-to-date listing of formulary drugs.

At providers.anthem.com/ny you can:

- Search more than 40,000 prescription drugs by name or therapeutic class
- Print a listing of formulary drugs*
- Download and print prior authorization forms
- View drugs with quantity limit*
- View drugs with step therapy*
- View drugs with prior authorization*
- View drugs that are considered specialty drugs*

*Subject to change anytime.

If you would like a copy of the formulary mailed to you, please call **800-450-8753**.

The abbreviated list below includes possible benefit exclusions:

- Prescription drugs dispensed at a non-participating provider
- Drugs prescribed for cosmetic purposes only
- Drugs prescribed for sexual dysfunction
- Prescription drugs when there is an over-the-counter (OTC) equivalent
- Appetite suppressants, except when prescribed by a physician to treat a medically necessary condition

- Injectable drugs other than self-administered injectables
- Cost of administration or injection of any drug
- Drugs not prescribed by a provider acting within the scope of his/her license
- Investigational, or experimental drugs or therapies

Drugs dispensed in a hospital or institution
Drugs marked as benefit exclusion on formulary search tool

Additional exclusions may apply under the terms of the member's contract.

Over-the-counter (OTC) medications are included in the PDL and are covered if prescribed by a physician for Essential Plan 3 and 4 members only. Select OTC drugs, where there is a prescription version, are covered for Essential Plan 1, 2, and 200-250 members.

Prior Authorization for Pharmacy Benefit Drugs
We strongly encourage you to write prescriptions for preferred products as listed on the appropriate PDL. If, for medical reasons, a member cannot use a preferred product, you are required to contact Pharmacy Services to obtain prior authorization (PA). Please note that certain drugs on the PDL may be subject to a medical necessity PA.

PA may be requested by submitting an electronic PA through (**covermymeds.com**) or Surescripts. Providers will be able to verify the status of a PA on the portal after electronic submission. PAs may also be submitted by calling Provider Services at **800-450-8753**. Be prepared to provide relevant clinical information regarding the member's need for a non-preferred product or a medication requiring PA. Decisions are based on medical necessity and are determined according to certain established medical criteria (not applicable to drugs that are benefit exclusions). A Prior Authorization form for Anthem members can also be found on our website at providers.anthem.com/ny > **Resources** > **Forms > Prior authorization form for prescriptions**.

Please use Pharmacy Hot Tips on our website to easily identify preferred products for common therapeutic categories.

Medical Injectables (Physician Administered Drugs)
Many medical injectables obtained directly by a medical provider or infusion pharmacy, and administered in a medical setting or for home infusion may require pre-certification. To determine whether the medical injectable you are prescribing requires pre-certification, please refer to the Prior Authorization Lookup tool at providers.anthem.com/ny > **Claims** > **Prior Authorization Lookup Tool**. The medical policy or clinical UM guidelines can be found at anthembluecross.com/provider/policies/clinical-guidelines/. PA may be requested by submitting an electronic PA through CoverMyMeds.

PA may also be submitted by calling Provider Services at **800-450-8753**. Be prepared to provide relevant clinical information regarding the member's need for a nonpreferred

product or a medication requiring PA. Decisions are based on medical necessity and are determined in accordance with certain established medical criteria (not applicable to drugs that are benefit exclusions).

A Prior Authorization form for Anthem members can also be found on our website at providers.anthem.com/ny > **Resources** > **Forms > Prior Authorization (PA) Form Medical Injectables,** and submitted by fax. To ensure efficient processing of your PA requests, submit relevant clinical information regarding the member's need for the requested medication along with the fax form.

Specialty Drug Program
Our Anthem members have the option to fill their specialty medication at our Preferred Specialty Pharmacy, BioPlus, or other providers in our specialty network. The list of approved specialty drug dispensing pharmacies can be found on our member portal specialty pharmacy page and is updated regularly.

Specialty pharmacies serve members with complex or chronic conditions. Specialty medications are used to treat these conditions and often require special storage or extra support. Specialty pharmacies have highly trained pharmacists and nurses to provide personal care and guidance to help members manage their condition.

With BioPlus Specialty Pharmacy, members get:

- Free shipping with confidential, on-time delivery
- 24/7 access to trained professionals
- Individualized care

To schedule delivery for specialty medications, members can contact BioPlus Care Team at **833-549-2115 (TTY 711), 24 hours a day, seven days a week**.

Prescribers can send electronic prescription to BioPlus Specialty Pharmacy, and may need to fill out a specialty pharmacy form in addition to calling or faxing in a valid New York State prescription to the pharmacy that the member has chosen.

Prescription Monitoring Program Registry
Effective August 27, 2013, most prescribers are required to consult the Prescription Monitoring Program (PMP) Registry when writing prescriptions for Schedule II, III, and IV controlled substances. The PMP Registry provides practitioners with direct, secure access to view dispensed controlled substance prescription histories for their patients.

Opioids
Per New York state regulations, the prescriber may not initially prescribe more than a 7-day supply of an opioid medication for acute pain. This rule does not include prescribing for chronic pain, pain being treated as a part of cancer care, hospice or other end-of-life care, or

palliative care. Upon any subsequent consultations for the same pain, the practitioner may issue, in accordance with existing rules and regulations, any appropriate renewal, refill, or new prescription for an opioid.

Anthem limits coverage of initial prescription of short-acting opioids to 7-day supply, and subsequent prescriptions to 7-day supply for up to a total of 14-day supply in 30 days. Prescriptions for long-acting opioids require prior authorization regardless of day supply. Exceptions are given to patients being treated for cancer, in hospice or palliative care.

Controlled Substance

The following limitations apply:
Prior authorization is required when member fills more than 4 opioid prescriptions within 30 rolling days (exceptions are given to patients being treated for cancer, sickle cell anemia and long term care pharmacy claims).
Faxed and oral prescriptions are limited to 5-day supply.
Prescriptions must be filled for the first time within 30 days of issuance, and refills within 180 days of issuance.

Medication Assisted Treatment

At least one drug from each type of MAT does not require prior authorization.

Restricted Recipient Program — Pharmacy

Anthem promotes member safety through coordination of care through the Restricted Recipient Program (RRP). The program is based on the member's utilization of prescribers, medications, and pharmacies or through referral by a provider, outside agency, health plan, or in cases of fraud and abuse. Members identified as candidates for the Restricted Recipient Program (RRP) are assigned to a single pharmacy for all pharmacy prescriptions.

Additional information on the program can be found under *Restricted Recipient Program*.

Split Fill Program

The split fill program is designed to prevent wasted prescription drugs if the treatment plan changes. The prescription drugs included in this program have been identified as requiring more frequent follow-up to monitor response to treatment and reactions. The initial and/or the second prescription are limited to a 15-day supply or small-sized tube for topical agents.

Pharmacy Clinical Programs

To help our providers deliver high-quality and comprehensive care, Anthem may offer information and recommendations as part of the many tools providers use to determine treatment plans. The information is either mailed or faxed to our providers. Programs include topics on:

- HEDIS® measures

Controlled substance utilization monitoring

- Asthma management
- Diabetes management
- Depression/Psychosis management
- Polypharmacy

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

Vaccines
Most vaccines are covered as pharmacy benefits for preventative care.

Colonoscopy Prep
Colonoscopy preps are available on the formulary for preventative care for members starting at age 45.

Exclusions and Limitations
No coverage is available under the Essential Plan for the following:
Aviation — We do not cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.
Convalescent and custodial care — We do not cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include covered services determined to be medically necessary.

- **Cosmetic services —** We do not cover cosmetic services, prescription drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection, or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly which has resulted in a functional defect. We also cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this contract. Cosmetic surgery does not include surgery determined to be medically necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of the contract unless medical information is submitted.
- **Coverage outside of the United States, Canada, or Mexico —** We do not cover care or treatment provided outside of the United States, its possessions, Canada, or Mexico except for emergency services, pre-hospital emergency medical services, and ambulance services to treat the patient's emergency condition.
- **Experimental or investigational treatment —** We do not cover any health care service, procedure, treatment, device, or prescription drug that is experimental or investigational. However, we will cover experimental or investigational treatments,

including treatment for the patient's rare disease or patient costs for the patient's participation in a clinical trial as described in the Outpatient and Professional Services section of this contract, or when our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, we will not cover the costs of any investigational drugs or devices, non-health services required for the patient to receive the treatment, the costs of managing the research, or costs that would not be covered under this contract for non-investigational treatments. See the Utilization Review and External Appeal sections of this contract for a further explanation of the member's Appeal rights.

Felony participation — We do not cover any illness, treatment, or medical condition due to your participation in a felony, riot, or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of your medical condition (including both physical and mental health conditions).

- **Foot care —** We do not cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet, except as stated in the contract. However, we will cover foot care when you have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in your legs or feet.
- **Government facility —** We do not cover care or treatment provided in a hospital that is owned or operated by any federal, state, or other governmental entity, except as otherwise required by law unless you are taken to the hospital because it is close to the place where you were injured or became ill and emergency services are provided to treat your emergency condition.
- **Medically necessary —** In general, we will not cover any health care service, procedure, treatment, test, device, or prescription drug that we determine is not medically necessary. If an External Appeal Agent certified by the State overturns our denial, however, we will cover the service, procedure, treatment, test, device or prescription drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or prescription drug is otherwise covered under the terms of this contract.
- **Medicare or other governmental program —** We do not cover services if benefits are provided for such services under the federal Medicare program or other governmental program.
- **Military service —** We do not cover an illness, treatment, or medical condition due to service in the Armed Forces or auxiliary units.

No-fault automobile insurance — We do not cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if you do not make a proper or timely claim for the benefits available to you under a mandatory no-fault policy.

- **Services not listed —** We do not cover services that are not listed in this contract as being covered.

- **Services provided by a family member —** We do not cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister, or brother of you or your Spouse.

Services separately billed by hospital employees — We do not cover services rendered and separately billed by employees of hospitals, laboratories, or other institutions.

- **Services with no charge —** We do not cover services for which no charge is normally made.

Vision services — We do not cover the examination or fitting of eyeglasses or contact lenses except as specifically stated in the Routine Vision Care section of this contract.

- **War —** We do not cover an illness, treatment, or medical condition due to war, declared or undeclared.
- **Workers' Compensation —** We do not cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability, or occupational disease law.

5 PRECERTIFICATION

Elective Inpatient Admissions

Anthem requires precertification of all inpatient elective admissions. The referring primary care or specialist physician is responsible for precertification. The referring physician identifies the need to schedule a hospital admission and must submit the request to the Anthem Medical Management department.

Requests for precertification with all supporting documentation should be submitted immediately upon identifying the inpatient request or at least 72 hours prior to the scheduled admission. This will allow Anthem to verify benefits and process the precertification request. For services that require precertification, Anthem makes case-by-case determinations that consider individuals' healthcare needs and medical histories in conjunction with MCG criteria.

The hospital can confirm that an authorization is on file by accessing Availity Essentials and either locating authorization cases through *Authorization/Referral Inquiry* or Authorization/Referral Dashboard. The hospital also has the option to call **800-450-8753** (see Section 13 of this manual for instructions). If coverage of an admission has not been approved, the facility should call Anthem at **800-450-8753**. Anthem will contact the referring physician directly to resolve the issue.

Anthem is available 24 hours a day, 7 days a week to accept precertification requests. When a request is received from the physician via telephone or fax for medical services, 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 diagnostic and therapeutic procedures. When appropriate, the precertification nurse will assist the physician in identifying alternatives for health care delivery as supported by the medical director.

When the clinical information received is in accordance with the definition of medical necessity and in conjunction with MCG criteria, 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 medical director will contact the requesting physician to discuss the case.

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

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, the member's PCP and the member.

Behavioral Health Services
Notification or Request Prior Authorization
The quickest, most efficient way to request prior authorization is via the secure provider website at Availity.com. Through the secure provider website, you can access the Availity Authorization Application, which offers a streamlined and efficient experience for providers requesting inpatient and outpatient behavioral health services. Providers can also use this tool to inquire about previously submitted requests regardless of how they were submitted.
Initiate preauthorization requests online, eliminating the need to fax. Availity Essentials allows detailed text, photo images, and attachments to be submitted along with your request.
Review requests previously submitted via phone, fax, or other online tools.
Instant accessibility from almost anywhere, including after business hours.
Utilize the dashboard to provide a complete view of all utilization management requests with real-time status updates.

- **Real-time results** for some common procedures.
- **Access the Availity Authorization application** under *Authorizations and Referrals* in Availity Essentials.

You may also request authorization for inpatient mental health services by calling **800-450-8753**, 24/7, 365 days a year. Please be prepared to provide clinical information in support of the request at the time of the call. 21

In addition to Availity Essentials, providers can call or fax requests for services.

Emergent Admission Notification Requirements
Anthem prefers immediate notification by network hospitals of emergent admissions. Network hospitals must notify Anthem of emergent admissions within one business day. Anthem Medical Management staff will verify eligibility and determine benefit coverage.

Anthem is available 24 hours a day, 7 days a week to accept emergent admission notification at **800-450-8753**.

Coverage of emergent admissions is authorized based on review by a concurrent review nurse. When the clinical information received meets MCG criteria, an Anthem reference number will be issued to the hospital.

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

If the medical director denies coverage of the request, the appropriate denial letter will be mailed to the hospital, the member's PCP, and the member.

Nonemergent Outpatient and Ancillary Services: Precertification and Notification Requirements

Anthem requires precertification for coverage of selected non-emergent outpatient and ancillary services (see chart below). To ensure timeliness of the authorization, the facility and/or provider is expected to provide the following:

- Member name and ID
- Name, telephone number, and fax number of the 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)

The provider must advise the member prior to initiating care if a service is not covered by Anthem, and to state the cost of the service.

Services Requiring Precertification

Precertification is required for the following services:

Type of care	Limitations
Emergency care	
Non-Emergency Ambulance Transportation	We cover non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between facilities when the transport is any of the following: • From a non-participating hospital to a participating hospital; • To a hospital that provides a higher level of care that was not available at the original hospital; • To a more cost-effective acute care facility; or • From an acute care facility to a sub-acute setting. **Limitations:** • We do not cover travel or transportation expenses, unless connected to an emergency condition or due to a facility transfer approved by us, even though prescribed by a physician.

Type of care	Limitations
	• We do not cover non-ambulance transportation such as ambulette, van or taxi cab. • Coverage for air ambulance related to an emergency condition or air ambulance related to non-emergency transportation is provided when the patient's medical condition is such that transportation by land ambulance is not appropriate; and the patient's medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one (1) of the following is met: – The point of pick-up is inaccessible by land vehicle; or – Great distances or other obstacles (e.g., heavy traffic) prevent the patient's timely transfer to the nearest hospital with appropriate facilities.
Non-Emergent Transportation	Non-emergency transportation is only covered for Essential Plan 3 and Essential Plan 4 members. Transportation is provided through the State's vendor, Medical Answering Services, LLC (MAS) To arrange transportation, contact: • NYC (Bronx, Brooklyn, Manhattan, Queens, Staten Island): — MAS - **844-666-6270** • All other counties: — Medical Answering Services - **800-850-5340**
Urgent Care Center	Urgent care is medical care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency department care. Urgent care is typically available after normal business hours, including evenings and weekends. Urgent care is covered in our service area. In-Network: • We cover urgent care from a participating physician or a participating urgent care center. • We do not need to be contacted prior to or after an urgent care visit. • We cover urgent care from a non-participating urgent care center or physician outside our service area. We require preauthorization. If urgent care results in an emergency admission, please follow the instructions for emergency hospital admissions. Preauthorization required for out-of-network, urgent care.

Type of care	Limitations
Professional services and outpatient care	
Advanced Imaging Services	We cover PET scans, MRI, nuclear medicine, and CAT scans. • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services
Chiropractic Services	We cover chiropractic care when performed by a Doctor of Chiropractic ("chiropractor") in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation, and any modalities. Any laboratory tests will be covered in accordance with the terms and conditions of this contract. **To pre-authorize services, providers should call ASH at:** • Provider Services: **800-972-4226** Hours of operation: Monday-Friday 7 a.m. to 9 p.m. Eastern time • Providers should submit ASH Clinical Treatment Forms (Authorizations) by faxing ASH at **877-304-2746.** • Providers can obtain ASH's Clinical Treatment Forms by visiting: ASHLink.com
Clinical Trials	**Clinical trials** We cover the routine patient costs for participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if the member is: • Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and • Referred by a participating provider who has concluded that the patient's participation in the approved clinical trial would be appropriate. All other clinical trials, including when the member does not have cancer or other life-threatening disease or condition, may be subject to the Utilization Review and External Appeal sections of this contract. We do not cover: The costs of the investigational drugs or devices; the costs of non-health services required for the member to receive

Type of care	Limitations
	the treatment; the costs of managing the research; or costs that would not be covered under this contract for non-investigational treatments provided in the clinical trial. An approved clinical trial means a phase I, II III, or IV clinical trial that is: • A federally funded or approved trial; • Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or • A drug trial that is exempt from having to make an investigational new drug application.
Habilitation Services (Physical, Occupational or Speech Therapy)	We cover habilitation services consisting of physical therapy, speech therapy and occupational therapy in the outpatient department of a facility or in a health care professional's office for up to 60 visits per plan year. The visit limit applies to all therapies combined. For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.
Home Health Care	We cover care provided in the patient's home by a home health agency certified or licensed by the appropriate state agency. The care must be provided pursuant to the patient's physician's written treatment plan and must be in lieu of hospitalization or confinement in a skilled nursing facility. Home care includes: • Part-time or intermittent nursing care by or under the supervision of a registered professional nurse; • Part-time or intermittent services of a home health aide; • Physical, occupational, or speech therapy provided by the home health agency; and • Medical supplies, prescription drugs, and medications prescribed by a physician and laboratory services by or on behalf of the home health agency to the extent such items would have been covered during a hospitalization or confinement in a skilled nursing facility. Home health care is limited to 40 visits per plan year. Each visit by a member of the home health agency is considered one (1) visit. Each visit of up to four (4) hours by a home health aide is considered one (1) visit. Any rehabilitation or habilitation services received under this benefit will not reduce the number of services available under the rehabilitation or habilitation services benefits.
Infusion Therapy	We cover infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have

Type of care	Limitations
	required the member to be hospitalized. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected are not considered infusion therapy. The services must be ordered by a physician or other authorized health care professional and provided in an office or by an agency licensed or certified to provide infusion therapy. Any visits for home infusion therapy count toward the member's home health care visit limit.
Inpatient Medical Visits	Admission authorization is required.
Therapeutic Radiology Services	• Performed in a freestanding radiology facility or specialist office • Performed as outpatient hospital services
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	We cover rehabilitation services consisting of physical therapy, speech therapy, and occupational therapy in the outpatient department of a facility or in a healthcare professional's office for up to 60 visits per condition per plan year. The visit limit applies to all therapies combined. For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy: • We cover speech and physical therapy only when: – Such therapy is related to the treatment or diagnosis of your physical illness or injury; – The therapy is ordered by a physician; and – You have been hospitalized or have undergone surgery for such illness or injury. • Covered rehabilitation services must begin within six (6) months of the later to occur: – The date of the injury or illness that caused the need for the therapy; – The date you are discharged from a hospital where surgical treatment was rendered; or – The date outpatient surgical care is rendered. In no event will the therapy continue beyond 365 days after such event. **To preauthorize services, providers should contact Carelon Medical Benefits Management:** Access Carelon Medical Benefits Management via the Availity Web Portal at Availity.com.

Type of care	Limitations
	Call the Carelon Medical Benefits Management Contact Center toll-free number at 877-430-2288, Monday–Friday, 8 a.m. to 5 p.m. CT.
Second Opinions on the Diagnosis of Cancer, Surgery and Other	**Second cancer opinion** We cover a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer, or a recommendation of a course of treatment for cancer. The member may obtain a second opinion from a non-participating provider on an in-network basis [when the member's attending physician provides a written preauthorization to a non-participating specialist]: **1. Second surgical opinion** We cover a second surgical opinion by a qualified physician on the need for surgery. **2. Required second surgical opinion** We may require a second opinion before we preauthorize a surgical procedure. The second opinion must be given by a board-certified specialist who personally examines the patient. If the first and second opinions do not agree, the patient may obtain a third opinion. The second and third surgical opinion consultants may not perform the surgery on the patient. **Second opinions in other cases** There may be other instances when the patient will disagree with a provider's recommended course of treatment. In such cases, the patient may request that we designate another provider to render a second opinion. If the first and second opinions do not agree, we will designate another provider to render a third opinion. After completion of the second opinion process, we will preauthorize/approve covered services supported by a majority of the providers reviewing the case.
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive	We cover physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or specialist, assistant (including a physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia

Type of care	Limitations
and Corrective Surgery; Transplants; and Interruption of Pregnancy)	services provided as part of a surgical procedure when rendered by the surgeon or the surgeon's assistant. **Transplants** All transplants must be prescribed by the patient's specialist(s). Additionally, all transplants must be performed at hospitals that we have specifically approved and designated to perform these procedures. We cover the hospital and medical expenses, including donor search fees, of the member -recipient. We cover transplant services required by the patient when the patient serves as an organ donor only if the recipient is covered by us. We do not cover the medical expenses of a non-covered individual acting as a donor for the patient if the non-covered individual's expenses will be covered under another health plan or program. We do not cover: travel expenses, lodging, meals, or other accommodations for donors or guests; donor fees in connection with organ transplant surgery; or routine harvesting and storage of stem cells from newborn cord blood.
Additional services, equipment and devices	
ABA Treatment for Autism Spectrum Disorder	ABA services require preauthorization.
Assistive Communication Devices for Autism Spectrum Disorder	We cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, We cover the rental or purchase of assistive communication devices when ordered or prescribed by a licensed physician or a licensed psychologist if the patient is unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide the patient with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. [Coverage is limited to dedicated devices. We will only cover devices that generally are not useful to a person in the absence of a communication impairment. We do not cover items, such as, but not limited to, laptop, desktop or tablet computers.] We cover software and/or applications that enable a laptop, desktop or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not

Type of care	Limitations
	separately reimbursable. We will determine whether the device should be purchased or rented. We cover repair, replacement fitting, and adjustments of such devices when made necessary by normal wear and tear or significant change in the patient's physical condition. We do not cover the cost of repair or replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft. However, we cover one repair or replacement per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to the patient's current functional level. We do not cover delivery service charges or routine maintenance.
Durable Medical Equipment and Braces	**Durable medical equipment and braces** We cover the rental or purchase of durable medical equipment and braces. **Durable medical equipment** Durable medical equipment is equipment which is: • Designed and intended for repeated use; • Primarily and customarily used to serve a medical purpose; • Generally, not useful to a person in the absence of disease or injury; and • Appropriate for use in the home. Coverage is for standard equipment only. We cover the cost of repair or replacement when made necessary by normal wear and tear. We do not cover the cost of repair or replacement that is the result of misuse or abuse. We will determine whether to rent or purchase such equipment. We do not cover over-the-counter durable medical equipment. We do not cover equipment designed for the patient's comfort or convenience (e.g., pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment), as it does not meet the definition of durable medical equipment. **Braces** We cover braces, including orthotic braces, that are worn externally and that temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease, or defect. Coverage is for standard

Type of care	Limitations
	equipment only. We cover replacements when growth or a change in the patient's medical condition makes replacement necessary. We do not cover the cost of repair or replacement that is the result of misuse or abuse.
External Hearing Aids **(Single purchase one every three (3) years)**	We cover hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver. Covered services are available for a hearing aid that is purchased as a result of a written recommendation by a physician and include the hearing aid and the charges for associated fitting and testing. We cover a single purchase (including repair and/or replacement) of hearing aids for one (1) or both ears once every three (3) years. Bone-anchored hearing aids are covered only if the patient has either of the following: • Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or • Hearing loss of sufficient severity would not be adequately remedied by a wearable hearing aid. If the patient meets the criteria for a bone-anchored hearing aid, coverage is provided for one (1) hearing aid per ear during the entire period that the patient is enrolled under this contract. We cover repair and/or replacement of a bone anchored hearing aid only for malfunctions.
Hospice Care	Hospice care is available if the primary attending physician has certified that the patient has six (6) months or less to live. We cover inpatient hospice care in a hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of hospice care. We cover hospice care only when provided as part of a hospice care program certified pursuant to Article 40 of the New York Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the hospice is located. We do not cover funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care.

Type of care	Limitations
Prosthetic Devices	**External prosthetic devices** We cover prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. We cover wigs only when the patient has severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not cover wigs made from human hair unless the patient is allergic to all synthetic wig materials: • We do not cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly. • We do not cover shoe inserts. • We cover external breast prostheses following a mastectomy, which are not subject to any lifetime limit. • Coverage is for standard equipment only. We cover the cost of one (1) prosthetic device, per limb, per lifetime. We also cover the cost of repair and replacement of the prosthetic device and its parts. We do not cover the cost of repair or replacement cover under warranty or if the repair or replacement is the result of misuse or abuse. **Internal prosthetic devices** We cover surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by the patient and the patient's attending physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear. Coverage is for standard equipment only.

Type of care	Limitations
Inpatient services and facilities	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	We cover inpatient hospital services for acute care or treatment given or ordered by a healthcare professional for an illness, injury, or disease of a severity that must be treated on an inpatient basis. The cost-sharing requirements in the Schedule of Benefits section of this contract apply to continuous hospital confinement, which is consecutive days of in-hospital service received as an inpatient or successive confinements when discharge from and readmission to the hospital occur within a period of not more than 90 days. Preauthorization is not required for emergency admissions.
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	We cover services provided in a skilled nursing facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. Custodial, convalescent or domiciliary care is not covered (see the Exclusions and Limitations section of this contract). An admission to a skilled nursing facility must be supported by a treatment plan prepared by the patient's provider and approved by us. We cover up to 200 days per plan year for non-custodial care.
Inpatient Rehabilitation Services (Physical, Speech, and Occupational Therapy)	We cover inpatient rehabilitation services consisting of physical therapy, speech therapy and occupational therapy for up to one (1) consecutive 60-day period per condition per lifetime. For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy. We cover speech and physical therapy only when: • Such therapy is related to the treatment or diagnosis of the patient's physical illness or injury; • The therapy is ordered by a physician; and • The patient has been hospitalized or has undergone surgery for such illness or injury. Covered rehabilitation services must begin within six (6) months of the later to occur: • The date of the injury or illness that caused the need for the therapy; • The date the patient is discharged from a hospital where surgical treatment was rendered; or • The date outpatient surgical care is rendered.

Type of care	Limitations
Mental health and substance use disorder services	
Inpatient Mental Health Care (for a continuous confinement when in a hospital)	We cover inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders comparable to other similar hospital, medical and surgical coverage provided under this contract. Coverage for inpatient services for mental health care is limited to facilities defined in New York Mental Hygiene Law Section 1.03(10), such as: • A psychiatric center or inpatient facility under the jurisdiction of the New York State Office of Mental Health • A state or local government run psychiatric inpatient facility • A part of a hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health • A comprehensive psychiatric emergency program or other facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health We also cover inpatient mental health care services relating to the diagnosis and treatment of mental, nervous, and emotional disorders received at facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to Article 27-J of the New York Public Health Law; and, in other states, to facilities that are licensed or certified to provide the same level of treatment. Preauthorization is not required for emergency admissions.
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	We cover outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous, and emotional disorders. Coverage for outpatient services for mental health care includes facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the New York State Office of Mental Health and, in other states, to similarly licensed or certified facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker who has at least three (3) years of additional experience in

Type of care	Limitations
	psychotherapy; a licensed mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst; or a professional corporation or a university faculty practice corporation thereof. We do not cover: • Benefits or services deemed to be cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs; • Mental health benefits or services for individuals who are incarcerated, confined, or committed to a local correctional facility or prison; or • Services solely because they are ordered by a court.
Inpatient Substance Use Services (for a continuous confinement when in a hospital)	We cover inpatient substance use services relating to the diagnosis and treatment of substance use disorder. This includes coverage for detoxification and rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance use services are limited to facilities in New York State that are certified by the Office of Alcoholism and Substance Abuse Services ("OASAS"); and, in other states, to those facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. We also cover inpatient substance use services relating to the diagnosis and treatment of substance use disorder received at facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to OASAS-certified facilities that provide services defined in 14 NYCRR 819.2(a)(1) and Part 817; and, in other states, to those facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment. Preauthorization is not required for emergency admissions.
Outpatient Substance Use Services	We cover outpatient substance use services relating to the diagnosis and treatment substance use disorder, including methadone treatment. Such coverage is limited to facilities in New York State that are certified by OASAS or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs, and, in other states, to those that are licensed or

Type of care	Limitations
	certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.
Out-of-Area/ Out-of-Network Care	• Precertification is required with the exception of emergency care (including self-referral). • Out-of-area care is only covered for emergent services; elective services are not covered. • Out-of-network care is only covered in instances of continuity of care for new members, instances where the provider leaves the network or if an in-network provider is not available to perform the service. **BlueCard® Program —** The BlueCard Program is a national program that enables members to obtain healthcare services while traveling or living in another BlueCross and BlueShield (BCBS) Plan area to receive all the same benefits as they would receive in the area of the plan issuing their coverage. Essential Plan members do not have access to the BlueCard® Program.

For services that require precertification, we use MCG Criteria to determine medical necessity for both inpatient and outpatient services in most of our precertification and concurrent review processes. For Substance Use Services we use LOCADTR and for Mental Health Services, starting in September 2022 we will use InterQual

We're 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 we receive your request for medical services via 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 you in identifying alternatives for health care delivery as supported by the medical director.

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

If the request is urgent (expedited service), the decision will be made within 24 hours.

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

If the medical director denies the request for coverage, the appropriate notice of proposed action will be mailed to the requesting provider, the member's primary physician, the facility and the member.

Inpatient Admission Reviews

All inpatient hospital admissions, including urgent and emergent admissions, will be reviewed within one business day. An Anthem Utilization Review (UR) clinician determines the member's medical status through communication with the hospital's UR department. 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 the medical director for possible coordination by the care management program.

Inpatient Concurrent Review

Each network hospital will have an assigned Utilization Management (UM) clinician. Each UM clinician will conduct a concurrent review of the hospital medical records to determine the precertification of coverage for a continued stay.

The UM clinician will conduct continued stay reviews daily and review discharge plans, unless the patient's condition is such that it is unlikely to change within the upcoming 24 hours and discharge planning needs cannot be determined.

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.

Our UM clinicians will help coordinate discharge planning needs with the hospital utilization review staff and attending physicians. The attending physician is expected to coordinate with the member's PCP regarding follow-up care after discharge. The PCP 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 the consumer has secured an appointment for a follow-up visit with a behavioral health provider to occur within seven calendar days of discharge.

We will authorize a covered length of stay based on the clinical information that supports the continued stay. For admissions subject to APR DRG methodology, initial authorizations will be based on presenting clinical and recommended length of stay based on APR DRG guidelines. For admissions subject to a per diem (daily rate), continued stay authorizations will occur as frequently as the clinical information requires.

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. Exceptions are made by the medical director. If, based upon appropriate criteria and after attempts to speak to the attending physician, the medical director denies coverage for an inpatient stay request, the appropriate notice of action will be mailed to the hospital, the member's primary care provider, and the member.

Continuity and Coordination of Care
Anthem encourages communication between all physicians, including primary care physicians (PCPs) and medical specialists, as well as other health care professionals who are involved in providing care to Anthem-covered individuals. Please discuss the importance of this communication with each covered individual and make every reasonable attempt to elicit their permission to coordinate care at the time treatment begins. HIPAA allows the exchange of information between covered entities for the purposes of treatment, payment, and healthcare operations.

Continuity of Care
Anthem's Medical Management will approve continued care depending upon the benefit plan if the member meets the conditions described below and the provider meets the outlined requirements:
When a member's PCP or specialist terminates from the plan and the member is receiving an ongoing course of treatment for a disabling, degenerative, or life-threatening condition, they may continue to receive covered treatment from the terminated provider for up to 90 days from the date the member received notice of the termination. After that, the member must choose a network provider. This policy also applies to pregnant women in the second or third trimester when they receive notice of their provider's termination from the plan. The provider may give covered services, including delivery and postpartum care directly related to the delivery.

Your participation agreement obligates you to continue to treat patients who are receiving a course of treatment from you at the time your participation terminates. Specifically, you are required to continue treating these patients and to continue accepting the rates applicable under your participation agreement, until the completion of their course of treatment or appropriate transfer to another participating provider. This obligation applies to all products. In no such event shall a physician abandon any patient for any reason.

In all such cases, Anthem requires that the non-network provider:

- Meet Anthem's Quality Assurance standards.

Agree to accept as payment in full those payment rates that were in effect when they were a participating network provider.

- Agree to provide Anthem with all necessary information related to the care given to the member.

Agree to adhere to all relevant Anthem policies and procedures, including the rules regarding referrals and precertification of certain services.

6 PRIMARY CARE PHYSICIAN & PROVIDER RESPONSIBILITIES

Primary Care Physician

The Primary Care Physician (PCP) is a provider who has the responsibility for the complete care of their Anthem patient panel. 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 specialty care, authorizing hospital services, and maintaining the continuity of care.

The PCP responsibilities shall include, at a minimum:

Managing the medical and health care 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
- Providing the coordination necessary for the referral of patients to specialists and for the referral of patients

Maintaining a medical record of all services rendered by the PCP and other referral providers

Screening and treating patients for sexually transmitted diseases (STDs), reporting cases of STDs to the local public health agency, and cooperating in contact investigations in accordance with existing state and local laws and regulations

- Educating patients about the risk and prevention of sexually transmitted diseases (STDs)

A PCP must be a physician or network provider/subcontractor who provides or arranges for the delivery of medical services, including case management, to ensure all services which 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 (e.g., a Federally Qualified Health Center [FQHC] or Rural Health Center [RHC]) or outpatient clinic.

We encourage members to select a PCP who provides preventive and primary medical care, as well as authorization and coordination of all medically necessary specialty services. We encourage our members to make an appointment with their PCPs within 30 calendar days of their effective date of enrollment.

Provider Specialties

Physicians with the following specialties can apply for enrollment with us as a PCP:

- Family practitioner
- General practitioner
- General pediatrician
- General internist
- Nurse practitioners certified as specialists in family practice or pediatrics

To contract as a PCP, you must practice at the location listed in the enrollment agreement.

PCP Onsite Availability

We're 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:

- Enrollees must have access to an after-hours live voice for PCP and OB/GYN emergency consultation and care.

PCPs must offer 24-hours a day, 7-days a week telephone access for members.

— A 24-hour telephone service may be used if it is:
  - Answered by a designee such as an on-call physician or nurse practitioner with physician backup, or an answering service or answering machine. Note: If an answering machine is used, the message must direct the member to a live voice.
  - Maintained as a confidential line for member information and/or questions (Note: An answering machine is **not** acceptable).

- The PCP or another physician/nurse practitioner must be available to provide medically necessary services.

Covering physicians are required to follow the preauthorization guidelines.

- It is **not** acceptable to automatically direct the member to the emergency room when the PCP is not available.

We encourage our PCPs to offer after-hours office care in the evenings and on weekends.

Responsibilities of the PCP

The PCP is a network physician who has the responsibility for the complete care of their members, whether providing it himself or herself or by referral to the appropriate provider of care within the network. Below are highlights of the PCP's responsibilities.

The PCP shall:

Manage the medical and health care needs of members, including monitoring and following up on care provided by other providers, including provide coordination necessary for referrals to specialists and (both in- and out-of-network); and maintain a medical record of all services rendered by the PCP and other providers

Provide 24-hours a day, 7-days a week coverage; regular hours of operation should be clearly defined and communicated to members

- Provide services ethically and legally, provide all services in a culturally competent manner and meet the unique needs of members with special health care needs

Participate in any system established by Anthem 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 Anthem in any reasonable internal and external quality assurance, utilization review, continuing education and other similar programs established by Anthem

- Participate in and cooperate with the Anthem complaint and grievance procedures (Anthem will notify the PCP of any member grievance)

Not balance-bill members; however, the PCP is entitled to collect applicable copayments, coinsurance or permitted deductibles for certain services

Continue care in progress during and after termination of their contract for up to 90 days until a continuity-of-care plan is in place to transition the member to another provider or through 60 days postpartum care for pregnant members in accordance with applicable state laws and regulations

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 standards regarding blood-borne pathogens

Establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act

Support, cooperate and comply with the Anthem Quality Improvement Program initiatives and any related policies and procedures and provide quality care in a cost-effective and reasonable manner

Inform Anthem if a member objects to provisions 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 the members the opportunity to approve or refuse their release

Provide to members complete information concerning their diagnosis, evaluation, treatment and prognosis and give members the opportunity to participate in decisions involving their health care, except when contraindicated for medical reasons, the information will be made available to an appropriate person acting on the member's behalf

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 which 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 high-quality patient care

Agree any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of the clinical research shall be clearly contrasted with entries regarding the provision of non-research related care

Note: Anthem does *not* cover the use of any experimental procedures or experimental medications except under certain preauthorized circumstances.

Provider Changes

Providers contracted with Anthem should utilize Availity Essentials Provider Demographic Management (PDM) application hosted on **Availity.com** to request changes to existing practice information.

Request data updates via either one of the following options within Availity Essentials Provider Data Management (PDM):

Multi-payer platform option: Allows providers to make updates once and have that information sent to all participating health plans, submitting each change separately.

Upload Roster option: Allows providers to submit multiple updates within one spreadsheet via the Upload Rosters feature.

Visit anthembluecross.com/provider/provider-maintenance-form/ for up-to-date information on Roster Automation.

PCP Access and Availability

All providers are expected to meet the federal and state accessibility standards and those defined in the Americans with Disabilities Act (ADA) of 1990. Healthcare services provided through Anthem must be accessible to all members.

Anthem is dedicated to arranging access to care for our members. The ability of Anthem to provide quality access depends upon the accessibility of network providers. Providers are required to adhere to the following access standards:

Appointment Type	Appointment Standard
Emergent or emergency visits	Immediately upon presentation
Urgent visits	Within 24 hours of request or sooner as clinically indicated
Non-urgent symptomatic visits	Within 48 to 72 hours of request or sooner as clinically indicated
Routine non-urgent, preventive appointments	Within four weeks of request or sooner, as clinically indicated
Specialist referrals (not urgent)	Within four to six weeks of request
Adult baseline, routine physicals	Within 12 weeks from enrollment
Initial family planning visit	Within two weeks of request
Pursuant to an emergency or hospital discharge, mental health or substance follow-up visits with a participating provider (as included in the benefit package)	Within five days of request or as clinically indicated
Non-urgent mental health or substance abuse visits with a participating provider (as included in the benefit package)	Within two weeks of request
Provider visits to make health, mental health and substance abuse assessments for the purpose of	Within 10 days of request by an Anthem member

Appointment Type	Appointment Standard
making recommendations regarding a recipient's ability to perform work when requested by a LDSS	

Initial Prenatal Visit	Appointment Standard
First trimester	Within three weeks
Second trimester	Within two weeks
Third trimester	Within one week

Office Waiting Time	Appointment Standard
Routine scheduled appointments	No longer than one hour past scheduled appointment time
Walk-in for non-urgent needs	Within two hours of presentation to the office
Walk-in for urgent needs	Within one hour of presentation to the office or as clinically indicated

24-Hour Access to PCP and OB-GYN (After Hours)	Appointment Standard
Call/contact with service/office representative	Enrollees must have access to a live voice for after-hours PCP and OB/GYN emergency consultation and care. If the provider uses an answering machine, the message must direct the enrollee to a live voice.

Providers may not use discriminatory practices such as preference to other insured or private pay patients and/or separate waiting rooms or appointment days.

Anthem will routinely monitor providers' adherence to the access to care standards.

To ensure continuous 24-hour coverage, PCPs must maintain one of the following arrangements for their members to contact the PCP after normal business hours:

- Have the office telephones answered after hours by an answering service, which can contact the PCP or another designated network medical practitioner.

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 directing the member to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone; another recording is not acceptable.

- Have the office telephone transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or a designated Anthem network medical practitioner.

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 tells members to leave a message.
- Office telephone is answered after hours by a recording which directs members to go to an emergency room for any services needed.

Appointment Access and Availability Studies

NYSDOH requires Anthem to conduct access and availability studies quarterly to ensure appointment and access standards are met. A random sample is periodically selected from our provider network. Anthem staff then place calls to the selected providers' offices both during and after hours to ensure our members (your patients) may access care within state-mandated guidelines.

Anthem always studies and records the results of the study at the end of the call. A passing score denotes that the office has met or exceeded the standard for a particular appointment type or after-hours coverage. In the event a provider fails to meet the established guidelines at the time of the study (meaning that the appointment was not scheduled within the prescribed time), Anthem issues a written notice. The notice requests a written explanation of the provider's policy on 24-hour coverage and appointment availability, as well as a plan of correction addressing the specific measure(s) failed. Anthem reviews the correction plan and resurveys the provider for compliance within two months. If a provider is found to be non-compliant on the second survey, the provider's panel is immediately closed to new members. A plan of correction is requested, and a third survey is conducted. Failure of the third compliance survey results in the immediate termination of the provider.

PCP Panel Capacity

Physicians operating as PCPs within the Anthem provider network may not have more than 1,500 members assigned to their panels. Anthem monitors our provider network monthly to ensure no practice location exceeds the aforementioned limit. When a physician reaches 1,250 members, a letter is sent to the physician advising them of the 1,500-patient threshold.

A physician who employs a registered physician assistant (PA) or a certified nurse practitioner (NP) is able to increase their panel threshold to 2,400 patients. The physician should alert Anthem of the presence of a PA or NP at the time of credentialing via the standard application. If the PA or NP is employed after the initial credentialing date, the physician must notify Anthem by letter.

NPs acting as PCPs are able to service a panel of 1,000 members. The same procedure applies for panel capacity, except that the practitioner is notified when their panel reaches 750 members. **An NP is not able to increase panel capacity by employing a PA.**

Member Missed Appointments

Anthem members may sometimes cancel or not appear for necessary appointments and fail to reschedule the appointment. This can be detrimental to their health. Anthem requires providers to attempt to contact members who have 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.

Anthem members who frequently cancel or fail to show up for an appointment without rescheduling the appointment may need additional education in appropriate methods of accessing care. In these cases, please call your Provider Relations representative. Anthem 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 PCP.

Noncompliant Anthem Members

Anthem recognizes providers may need help in managing nonadherent 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 **800-450-8753**.

A Member Services representative will contact the member by telephone, or a member advocate will visit the member to provide the education and counseling to address the situation and will report to you the outcome of any counseling efforts.

PCP Transfers

To maintain continuity of care, Anthem encourages members to remain with their PCP. However, members may request to change their PCP for any reason by contacting Member Services at **800-300-8181**. The member's name will be provided to the PCP on the membership roster.

Members can call to request a PCP change any day of the month. PCP change requests will be processed generally on the same day or by the next business day. Members will receive a new ID card within 10 days.

Note: Members who have been placed on a PCP restriction can change PCP without cause every three months.

Continuity of Care (Provider Termination)

Continuity of Care (provider termination) applies in its entirety to all programs including Essential Plan.

If a provider leaves the network for reasons other than a determination of fraud, imminent harm to patient care or a final disciplinary action by a state licensing board that impairs the health professional's ability to practice, Anthem will permit a member to continue an ongoing course of treatment with that provider under the following circumstances:
If the member has a life-threatening, disabling, or degenerative condition, a rare disease, or is in an ongoing course of treatment, they may see the provider for 90 days from when the provider's contract expires.
If the member is in the second or third trimester of pregnancy, she may see the provider for all prenatal, delivery, and postpartum care directly related to the pregnancy.

In all cases, the provider must agree to Anthem policies, procedures, and reimbursement rates.

Anthem will immediately remove any provider from the network who is unable to provide health care services due to final disciplinary action.

Covering Physicians

During a provider's absence or unavailability, the provider needs to arrange for coverage for their members. The provider will either make arrangements with:

- One or more network providers to provide care for their members

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. Providers will be solely responsible for a non-network provider's adherence to such provisions. Providers will be solely responsible for any fees or monies due and owed to any non-network provider providing substitute coverage to a member on the provider's behalf.

Specialist as a PCP

Under certain circumstances, when a member requires the regular care of the specialist, a specialist may be approved by Anthem to serve as a member's PCP. The criteria for a specialist to serve as a member's PCP include the member having a chronic, life-threatening illness or 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; 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 participation (including contractual obligations and credentialing); provide access to care 24 hours a day, 7 days a week; and coordinate the member's treatment plan, including preventive care along with the member's PCP and Anthem. When such a need is identified, the member or specialist must contact the Anthem Case Management department and complete a Specialist as PCP Request form. An Anthem case manager will review the request and submit it to the Anthem medical director. Anthem will notify the member and the provider of our determination in writing within 30 days of receiving the request. Should Anthem deny the request, Anthem will provide written notification to the member and provider outlining the reason(s) for the denial of the request within one day of the decision. If the specialist or other health care provider needed to provide ongoing care for a specific condition is not available in the Anthem network, the referring physician will request authorization from Anthem for services outside the network.

The referral must be approved by Anthem and will be made pursuant to an approved treatment plan approved by Anthem, the member's PCP and nonparticipating physician. The member may not use a nonparticipating specialist unless there is not a specialist in the network that can provide the requested treatment. Specialists serving as PCPs will continue to be paid while serving as the member's PCP. The designation cannot be retroactive. Members may self-refer for unlimited behavioral health and substance use assessments (except for ACT, inpatient psychiatric hospitalization, partial hospitalization, and HCBS services). Visits for behavioral health services are coordinated by calling **800-450-8753**. Precertification is not required for behavioral health services when provided by a network provider. A provider or hospital must be contracted with Anthem to provide these services.

Specialty Referrals

To reduce the administrative burden on the provider's office staff, Anthem has established procedures designed to permit a member with a condition requiring ongoing care from a specialist physician or other healthcare provider to request an extended authorization (i.e., a standing referral).

The provider can request an extended referral authorization by contacting the member's PCP. The provider must supply the necessary clinical information that will be reviewed by the PCP to complete the authorization review.

On a case-by-case basis, an extended authorization will be approved. In the event of termination of a contract with the treating provider, the continuity of care provisions in the provider's contract with Anthem will apply. The provider may renew the authorization by submitting a new request to the PCP. Additionally, Anthem requires the specialist physician or other health care provider to provide regular updates to the member's PCP (unless acting also as the designated PCP for the member). Should the need arise for a secondary referral,

the specialist physician or other health care provider must contact Anthem for coverage determination.

If the specialist or other health care provider needed to provide ongoing care for a specific condition is not available in the Anthem network, the referring physician shall request authorization from Anthem for services outside the network. Access will be approved to a qualified non-network health care provider within a reasonable distance and travel time at no additional cost if medical necessity is met.

If a provider's application for an extended authorization is denied, the member (or the provider on behalf of the member) may appeal the decision through the Anthem medical appeal process. See the Adverse Determinations/Reconsideration/Appeals section of this manual for more information.

Services that do not require a referral

The following services do not need a referral from a PCP:

- Primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, treatment of Acute gynecologic conditions, or for any care related to a pregnancy from a qualified Participating provider of such services;
- Emergency Services
- Pre-hospital Emergency Medical Services and emergency ambulance transportation
- Urgent care
- Chiropractic services
- Outpatient mental health care
- Refractive eye exams from an optometrist

Referrals to Specialty Care Centers

Anthem has established procedures designed to permit a member with a life-threatening or degenerative and disabling condition or disease, which requires prolonged specialized medical care to receive a referral to an accredited or designated specialty care center with expertise in treating the life-threatening or degenerative and disabling disease or condition.

Specialty Care Providers

To participate in the Essential Plan, the provider must have applied for enrollment and be a licensed provider by the state before signing a contract with Anthem.

Anthem contracts 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 is responsible for providing specialized care for members, usually upon appropriate referral from a PCP within the network. (See the Role and Responsibility of the Specialty Care Provider section of this manual for more

information.) In addition to sharing many of the same responsibilities to members as PCPs (see Responsibilities of the PCP section), the specialty care provider offers services that include:

- Allergy and immunology services
- Burn services
- Community behavioral health (e.g., mental health and substance abuse) services
- Cardiology services
- Clinical nurse specialists, psychologists, clinical social workers – behavioral health
- Critical care medical services
- Dermatology services
- Endocrinology services
- Gastroenterology services
- General surgery
- Hematology/oncology services
- Neonatal services
- Nephrology services
- Neurology services
- Neurosurgery services
- Ophthalmology services
- Orthopedic surgery services
- Otolaryngology services
- Perinatal services
- Psychiatry (adult) assessment services
- Trauma services
- Urology services

Role and Responsibilities of the Specialty Care Provider

Specialist providers will only treat members who have been referred to them by network PCPs (except for mental health and substance abuse providers and services for which the member may self refer) and will render covered services only to the extent and duration indicated on the referral. Obligations of the specialists include but are not limited to:
Complying with all applicable statutory and regulatory requirements of the Essential Plan

- Accepting all members referred to them
- Submitting required claims information to Anthem, 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 on a timely basis following a referral or routinely scheduled consultative visit

- Notifying the member's PCP when scheduling a hospital admission or scheduling any procedure requiring the PCP's 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 shall:

Manage the medical and health care needs of members, including monitoring and following up on care provided by other providers, provide coordination necessary for referrals to other specialists; and maintain a medical record of all services rendered by the specialist and other providers

Provide 24-hours -a-day, 7-days --a week coverage and maintain regular hours of operation that are clearly defined and communicated to members

- Provide services ethically and legally, in a culturally competent manner and meet the unique needs of members with special health care requirements

Participate in the systems established by Anthem that facilitate the sharing of records, subject to applicable confidentiality and HIPAA requirements

Participate and cooperate with Anthem in any reasonable internal or external quality assurance, utilization review, continuing education, or other similar programs established 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 the Anthem complaint and grievance processes and procedures (Anthem will notify the specialist of any member grievance brought against the specialist)
- Not balance bill members

Continue care in progress during and after the termination of their contract for up to 90 days until a continuity of care plan is in place to transition the member to another provider or through 60 days postpartum care for pregnant members in accordance with applicable state laws and regulations

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 ADA applicable to his/her practice location

Support, cooperate, and comply with the Anthem Quality Improvement Program initiatives and any related policies and procedures designed to provide quality care in a cost-effective and reasonable manner

- Inform Anthem 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 members complete information concerning their diagnosis, evaluation, treatment, and prognosis, and give members the opportunity to participate in decisions involving their

health care, except when contraindicated for medical reasons, the information will be made available to an appropriate person acting on the member's behalf
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
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 patient'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.

Note: Anthem does not cover the use of any experimental procedures or experimental medications except under certain preauthorized circumstances.

Specialty Care Providers' Access and Availability

Anthem 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 Anthem to provide specialty services to members.

Specialists must adhere to the following access guidelines:

Service	Access Requirement
Urgent visit	Within 24 hours of request or sooner as clinically indicated
Nonurgent, nonemergency visits	Within 48–72 hours of request or sooner as clinically indicated
Routine nonurgent, preventive appointments	Within four to six weeks of request or sooner as clinically indicated
Prenatal care	Within two weeks of request

Member Records

Using nationally recognized standards of care, Anthem works with providers to develop clinical policies and guidelines of care for our membership. The Medical Advisory Committee (MAC) oversees and directs Anthem in formalizing, adopting, and monitoring guidelines. Anthem requires medical records to be maintained in a manner that is current, detailed, and organized and permits effective and confidential patient care and quality review. Anthem, NYSDOH, and CMS may have the right to access members' medical records for utilization review and quality management at any time.

Providers 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 and other providers. Medical records must be kept in accordance with Anthem and state standards as follows.

Medical Record Standards

The records reflect all aspects of patient care, including ancillary services. Documentation of each visit must include:

1. Date of service
2. Grievance or purpose of visit
3. Diagnosis or medical impression
4. Objective finding
5. Assessment of patient's findings
6. Plan of treatment, diagnostic tests, therapies, and other prescribed regimens
7. Medications prescribed
8. Health education provided
9. Signature and title, or initials, of the provider rendering the service; if more than one person documents in the medical record, there must be a record on file as to what signature is represented by which initials

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

1. **Patient identification information**: Each page or electronic file in the record must contain the patient's name or patient ID number.
2. **Personal/biographical data**: The record must include age, sex, address, employer, home and work telephone numbers, and marital status.
3. **Date and corroboration**: All entries must be dated with the 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** (for patients seen three or more times): Past medical history must be easily identified including serious accidents, operations, and illnesses.
7. **Diagnostic information**
8. **Medication information** (includes medication information/instruction to the patient)
9. **Identification of current problems**: Significant illnesses, medical and behavioral health conditions and health maintenance concerns must be identified in the medical record.
10. **Instructions**: The record must include evidence that the patient was provided with basic teaching and instruction regarding physical and/or behavioral health condition.

11. **Smoking/alcohol/substance abuse**: A notation concerning cigarettes and alcohol use and substance abuse must be stated if present for patients aged 12 and older. Abbreviations and symbols may be appropriate.
12. **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.
13. **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 patient is part of the PCP's panel must be noted.
14. **Hospital discharge summaries**: Discharge summaries for all hospital admissions that occur while the patient is enrolled and for prior admissions, as appropriate. Prior admissions that may have occurred before the patient was enrolled may be pertinent to the patient's current medical condition.
15. **Advance directive**: For adult patients, record 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 health care decision-making for individuals who are incapacitated.
16. **Security**: Providers must maintain a written policy as required to ensure that medical records are safeguarded against loss, destruction, or unauthorized use. Additionally, a provider must develop policies and procedures for their staff to ensure the confidentiality of HIV-related information. The policy and procedure for HIV must include:
    - Initial and annual in-service education of staff and/or contractors
    - Identification of staff-allowed access and limits of access
    - Procedures to limit access to trained staff (including contractors)
    - Protocol for secure storage (including electronic storage)
    - Procedures for handling requests for HIV-related information
    - Protocols to protect persons with or suspected of having HIV infection from discrimination
17. **Release of information**: Written procedures are required for the release of information and obtaining consent for treatment.
18. **Documentation**: Documentation is required setting forth the results of medical, preventive, and behavioral health screening, all treatment provided, and results of such treatment.
19. **Multidisciplinary teams**: Documentation is required of the team members involved in the multidisciplinary team of a patient needing specialty care.
20. **Integration of clinical care**: Documentation of the integration of clinical care in both the physical and behavioral health records is required. Such documentation must include:
    - Screening for behavioral health conditions (including those which may be affecting physical health care and vice versa) and referral to behavioral health providers when problems are indicated
    - Screening and referral by behavioral health providers to PCPs when appropriate

- Receipt of behavioral health referrals from physical medicine providers and the disposition/outcome of those referrals
- A summary of the status/progress from the behavioral health provider to the PCP, at least quarterly (or more often if clinically indicated)
- A written release of information that will permit specific information sharing between providers
- Documentation that behavioral health professionals are included in primary and specialty care service teams described in this contract when a patient with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder

21. **Provider reporting obligations**: Documentation of reasonable efforts to assure timely and accurate compliance with NYC public health reporting requirements in the following areas:
    - Infants and toddlers suspected of having a developmental delay or disability
    - Suspected instances of child abuse
    - Immunization Registry and Blood Lead Registry
    - Communicable disease and conditions mandated in the New York City Health Code, pursuant to 24 RCNY§ 11.03-11.07 and Article 21 of the NYS Public Health Law

Patient 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 patients receiving behavioral health treatment, documentation that includes at-risk factors (danger to self/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 patients 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 patients who receive behavioral health treatment, including evidence of family involvement and evidence the family was included in therapy sessions, each as applicable
8. For follow-up care encounter forms or notes with a notation indicating follow-up care, a call or a visit that must note in weeks or months 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 patient care, such as ancillary services

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

Anthem maintains an appropriate record-keeping system for services to 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 will be retained in accordance with the record retention requirements. A member's medical record must be retained by their provider for six years after the date of service rendered to the member, and in the case of a minor, for three years after majority or six years after the date of the service, whichever is later. Prenatal care medical records will be centralized for all other services.

Advance Directives

Anthem respects 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.

Anthem adheres to the Patient Self-Determination Act and maintains written policies and procedures regarding advance directives. Advance directives are documents signed by a competent person giving directions to healthcare providers about treatment choices in certain circumstances. There are two types of advance directives: 1) a durable power of attorney for health care, and; 2) a living will. A durable power of attorney for health care (durable power) allows the member to name a patient advocate to act on behalf of the member. A living will allow the member to state their wishes in writing but does not name a patient advocate.

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

Members over 18 and emancipated minors can make advance directives. Their response is to be documented in the medical record. Anthem 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.

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

Anthem notes the presence of advance directives in the medical records when conducting medical chart audits. *Living Will and Durable Power of Attorney* forms are located in **Appendix A — Forms**.

Confidentiality of Information

Utilization management, case management, condition care, discharge planning, quality management, and claims payment activities are designed to ensure patient-specific information, particularly protected health information obtained during review. Information is kept confidential in accordance with applicable laws, including HIPAA, and 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.

Emergency Services

We provide 24/7 NurseLine service with clinical staff to provide triage advice, referral, and, if necessary, to make arrangements for treatment of the member. The staff has access to qualified behavioral health professionals to assess behavioral health emergencies.

We do *not* discourage members from using the 911 emergency system or deny access to emergency services. Emergency services are provided to members without requiring precertification. Emergency services coverage includes services 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.

An emergency medical condition is defined as a physical or behavioral 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 the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and/or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- 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 the provider for screening, evaluation and examination, reasonable and calculated, that assists the healthcare provider in determining whether or not the patient's condition is an emergency medical condition.

If there is concern surrounding the transfer of a patient (e.g., whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstable transfer outweigh the risks), the judgment of the attending physician(s) caring for the member at the treating facility prevails and is binding on Anthem. 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 nonnetwork. All transfers from non-network to network facilities are to be conducted only after the member is medically stable and the facility can render the required level of care.

If a member is admitted, the facility is required to notify us. Upon notification, our concurrent review nurse will implement the concurrent review process to ensure coordination of care.

Medically Necessary Services
Medically necessary health services are defined as health services that meet all or one of the following conditions:

- Services are essential to prevent, diagnose, prevent the worsening of, alleviate, correct or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, result in illness or infirmity of a member, or interfere with such person's capacity for normal activity.

Services are provided at an appropriate facility and at the appropriate level of care for the treatment of the member's medical condition.
Services are provided in accordance with generally accepted standards of medical practice.

Note: We do *not* cover the use of any experimental procedures or experimental medications except under certain preauthorized circumstances.

If experimental or investigational services are requested, the attending physician will:

- Certify that the member has a life-threatening or disabling condition for which:
  - The standard service/procedure has been ineffective or would be medically inappropriate
  - There does not exist a more beneficial standard service or procedure covered by the plan
  - There is a clinical trial that is open, the member is eligible to participate, and the member has or will likely be accepted
- Attest that the service or procedure is likely to be more beneficial to the member than any standard service or procedure based on two documents which are grounded in credible medical or scientific evidence (copies of these documents must be enclosed with the request)

7 MEDICAL AND UTILIZATION MANAGEMENT

Anthem's Medical Policy Review and Development

Medical Policies and Clinical Utilization Management (UM) Guidelines

Medical Policy

is the authorizing body for medical policy and clinical UM guidelines, which serve as a basis for coverage decisions. MPTAC is a multidisciplinary group including physicians from various medical specialties, clinical practice environments, and geographic areas. Voting memberships includes external physicians in clinical practices and participating in networks; external physicians in academic practices and participating in networks; and internal medical directors. Additional details, including information about the MPTAC and its subcommittees are provided in ADMIN.00001 Medical Policy Formation.

Medical Policy and Clinical Utilization Management (UM) Guidelines Distinction

Medical policy and clinical UM guidelines differ in the type of determination being made. In general, medical policy addresses the Medical Necessity of new services and/or procedures and new applications of existing services and/or procedures, while clinical UM guidelines focus on detailed selection criteria, goal length of stay (GLOS), or the place of service for generally accepted technologies or services. In addition, medical policies are implemented by all Anthem Plans while clinical UM guidelines are adopted and implemented at the Anthem Plan's discretion.

Medical Policies and Clinical UM Guidelines are posted online at **https://providers.anthem.com/ny**. All medical policies and clinical UM guidelines are publicly available on our website, which provides greater transparency for providers and facilities, covered individuals and the public in general.

To locate medical policies online, go to providers.anthem.com/ny. Select Provider Support > Quality Assurance. Under the Resources section, select Medical Policies.

To locate clinical UM guidelines online, go to providers.anthem.com/ny. Select Precertification & Claims. Under the Resources section, select Clinical UM Guidelines. On that page you can find the link to *Clinical Documentation Lookup Tool* to help you determine authorization requirements.

Medical Review Criteria

Anthem medical policies, which are publicly accessible from its Anthem subsidiary website, became the primary benefit plan policies for determining whether services are a) investigational/experimental, b) medically necessary, and c) cosmetic or reconstructive for Anthem subsidiaries.

MCG criteria will continue to be used when no specific Anthem medical policies exist. In the absence of licensed MCG criteria, Anthem subsidiaries may use Anthem Clinical Utilization Management (UM) Guidelines. A list of the specific Anthem Clinical UM Guidelines used will be posted and maintained on the Anthem subsidiary websites 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.

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 contracts or CMS requirements will supersede both MCG and 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.

Anthem follows established procedures for applying medical necessity criteria based on individual member needs and an assessment of the availability of services within the local delivery system. These procedures apply to precertification, concurrent reviews, and retrospective reviews. Utilization Management (UM) clinicians collect and review relevant clinical information to determine if the level of service requested meets medical necessity criteria. Criteria can be accessed via criteria-specific software and/or Web applications.

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

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

Anthem does not specifically reward practitioners or other individuals for issuing denial of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that 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.

Anthem does not employ utilization controls or other coverage limits to automatically place limits on the length of stay for members requiring hospitalization or surgery. Length of stay for a member's request for hospitalization or surgery is based on the needs of the member rather than on arbitrary limits. Members who are hospitalized or receiving surgical services are managed by an assigned utilization manager. The clinical review for these services will specify authorization for coverage limits as determined by clinical guidelines and individual needs. Subsequently, the utilization manager working with the hospital, PCP/attending physician, and other parties will monitor and continually review the case to determine discharge readiness and to facilitate discharge planning. For members found to require extended benefits, as identified by the concurrent review of individual needs, severity of illness, and services being rendered, the utilization manager has the authority to extend the hospital stay or other services as needed.

In the application of criteria, it is generally understood that these criteria are designed for uncomplicated patients and for a complete delivery system. This may not be appropriate for

patients with complications or for a delivery system with insufficient alternatives for care. Anthem will consider the following when applying criteria to a given individual:

- Age
- Comorbidities
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment when applicable

The characteristics of the local delivery system available for specific patients will also be considered, such as:

- Availability of skilled nursing facilities, subacute care facilities, or home care in the organization's service area to support the patient after hospital discharge
- Coverage of benefits for alternative levels of care when needed
- Provider ability to provide all recommended services within the estimated length of stay

Utilization managers are required to discuss all cases with the medical director in which medical necessity is not met using established criteria, or in which there is a failure of the local delivery system to provide care for final review determination. Utilization managers can only make determinations for approvals of care, and only a licensed medical director makes any adverse determinations. Trained nonclinical associates under the direct supervision of licensed clinical team members have the authority to approve services under procedures designated by the health plan. Anthem health plans monitor the accuracy and consistency of review decisions through health plan audits and corporate annual Inter-rater Reliability audits. Requests that do not meet criteria are referred to the medical director or clinical peer designee. All UM criteria used in rendering decisions are available upon request. Providers may request copies of the criteria- by calling Provider Services at **800-450-8753**.

Medical necessity determinations are based on approved clinical criteria and are made by appropriate clinical staff with unrestricted licensure. Anthem expects nurses and physicians who make decisions on coverage of care and services to:

- Make decisions based on the right care and services the benefit covers
- Understand Anthem does not reward providers or others if they deny coverage of care or services
- Make sure the money paid to decision-makers does not end in the misuse of needed healthcare

Authorization Request Process

Anthem may require members to obtain a referral from their PCP prior to accessing specialty care and out-of-network services. Anthem may also require providers to complete

a notification or precertification process prior to providing certain medically necessary services to members. Medically necessary services are health care services necessary to prevent, diagnose, manage, or treat conditions that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap. Providers may verify which services require notification or precertification by calling **800-450-8753** or visiting our website and using the Precertification Lookup tool online (PLUTO). Anthem is available to respond to questions or provide specific information regarding requests for authorization between 8:30 a.m. and 5:30 p.m. ET. Voice messages left after business hours will be returned on the next business day.

Utilization Review Delegation

Anthem may delegate utilization review (UR) activities for select services to an approved, accredited UR agent. In those instances, providers should refer to the provider web portal to confirm the appropriate agent and contact information to initiate the authorization request process. All delegated agents follow the Anthem UR processing guidelines, including time frames and notification for authorization, in adherence with the state Medicaid contract.

Utilization Review Definitions

The benefits available under this contract are subject to pre-service, concurrent and retrospective reviews to determine when services should be covered by us. The purpose of these reviews is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place where the services are performed. Covered services must be medically necessary for benefits to be provided.

Utilization Review

We review health services to determine whether the services are or were medically necessary or experimental or investigational ("medically necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If you have any questions about the Utilization Review process, please call **800-450-8753** or via our website.

All determinations that services are not medically necessary will be made by: 1) licensed physicians; or 2) licensed, certified, registered, or credentialed healthcare professionals who are in the same profession and same or similar specialty as the provider who typically manages the patient's medical condition or disease or provides the health care service under review; or 3) with respect to substance use disorder treatment, licensed physicians or licensed, certified, registered or credentialed health care professionals who specialize in behavioral health and have experience in the delivery of substance use disorder courses of treatment. We do not compensate or provide financial incentives to our employees or reviewers for determining that services are not medically necessary. We have developed guidelines and protocols to assist us in this process. Specific guidelines and protocols are available for review upon request. For more information, please call **800-450-8753** or via our

website providers.anthem.com/ny.

Time frames summarized in the paragraphs below are Article 49 NYS regulatory requirements. As a quality-focused organization, Anthem has elected to attain NCQA accreditation. NCQA time frames differ from NYS regulatory requirements; therefore, in order to meet both NCQA and NYS regulatory requirements, Anthem will follow the most stringent time frames. See Tables 1 and 2 at the end of this section for a comparison between time frames.

Preauthorization Reviews

Non-urgent preauthorization reviews If we have all the information necessary to make a determination regarding a preauthorization review, we will make a determination and provide notice to the patient's (or the patient's designee) and the patient's provider, by telephone and in writing, within three (3) business days of receipt of the request.

If we need additional information, we will request it within three (3) business days. The patient or the patient's provider will then have 45 calendar days to submit the information. If we receive the requested information within 45 days, we will make a determination and provide notice to the patient (or the patient's designee) and the patient's provider, by telephone and in writing, within three (3) business days of our receipt of the information. If all necessary information is not received within 45 days, we will make a determination within 15 calendar days of the end of the 45-day period and not to exceed 60 calendar days from the date of request.

Urgent (Expedited) Precertification Reviews

An expedited review of a precertification request must be conducted when Anthem or the provider indicates the delay would seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum functions. Members have the right to request an expedited review, but Anthem may deny and notify the member that the review will be processed under standard review time frames. In the case of an expedited review, a decision and notification will be made as fast as the member's condition requires and no later than 72 hours after receipt of the request

With respect to urgent preauthorization requests, if we have all information necessary to make a determination, we will make a determination and provide notice to the patient (or the patient's designee) and the patient's provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within 72 hours from the receipt of the request. If we need additional information, we will request it within 24 hours. The patient or the patient's provider will then have 48 hours to submit the information. We will make a determination and provide notice to the patient (or the patient's designee) and the patient's provider by telephone and in writing within 48 hours of the earlier of our receipt of the information or the end of the 48-hour period. Written and verbal notification will be provided within 72 hours from our receipt of the information.

Predetermination Overview

Anthem has established a predetermination process for services where precertification is not required, and you can confirm in advance of providing the service whether the service meets medical policy criteria. The predetermination enables the member and physician or other health care provider to verify the service meets our medical necessity criteria before delivering the care. Although a predetermination is not required, we encourage physicians or other healthcare providers to obtain one prior to performing any of these procedures.

When a predetermination is not obtained prior to the procedure, the claim for the service will be reviewed for medical necessity on a retrospective basis. In cases when an adverse determination is issued, you and the member may access available appeal levels before delivery of the service. The medical necessity criterion is available online for your review at providers.anthem.com/ny.

You can confirm the precertification requirement by contacting the health plan using the precertification number on the member's ID card. If you are advised precertification is not required, but you would like to ensure coverage and payment for services prior to rendering, you can request a predetermination review, and your request will be reviewed with the applicable clinical guidelines and within preauthorization timeframes.

Court Ordered Treatment

Effective on the date of issuance or renewal of this contract on or after April 1, 2016, with respect to requests for mental health and/or substance use disorder services that have not yet been provided, if the patient (or the patient's designee) certify, in a format prescribed by the Superintendent of Financial Services, that the patient will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, we will make a determination and provide notice to the patient (or the patient's designee) and the patient's provider by telephone within 72 hours of receipt of the request. Written notification will be provided within three (3) business days of our receipt of the request. Where feasible, telephonic and written notification will also be provided to the court.

Concurrent Reviews

A concurrent review is the review of a request for continued, extended, or more of an authorized service than what is currently authorized by Anthem. Concurrent review requests for medical can be submitted by phone at **800-450-8753**, via fax to **800-964-3627,** or via our website at providers.anthem.com/ny. Physical health concurrent reviews should be submitted via providers.anthem.com/ny.

Nonurgent Concurrent Reviews

In the case of a standard, nonurgent concurrent review a decision will be made, and notice provided to the patient (or the patient's designee), by telephone and in writing, within one (1) business day of receipt of all necessary information. If we need additional information, we

will request it within one (1) business day. The patient or the patient's provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to the patient (or the patient's designee), by telephone and in writing, within one (1) business day of our receipt of the information or, if we do not receive the information, within 15 calendar days of the end of the 45-day period but no longer than 60 calendar days from the date of the request.

Urgent Concurrent Reviews

For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, we will make a determination and provide notice to the patient (or the patient's designee) by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and we have all the information necessary to make a determination, we will make a determination and provide written notice to the patient (or the patient's designee) and the patient's provider within the earlier of 72 hours or one (1) business day of receipt of the request. If we need additional information, we will request it within 24 hours. The patient or the patient's provider will then have 48 hours to submit the information. We will make a determination and provide written notice to the patient (or the patient's designee) within the earlier one (1) business day or 48 hours of our receipt of the information or, if we do not receive the information, within 48 hours of the end of the 48-hour period.

Home Health Care Reviews

After receiving a request for coverage of home care services following an inpatient hospital admission, we will make a determination and provide notice to the patient or the patient's designee and the patient's provider, by telephone and in writing, within one (1) business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, we will make a determination and provide notice to the patient (or the patient's designee) within 72 hours of receipt of the necessary information. When we receive a request for home care services and all necessary information prior to the patient's discharge from an inpatient hospital admission, we will not deny coverage for home care services while our decision on the request is pending.

Inpatient Substance Use Disorder Treatment Reviews

If a request for inpatient substance use disorder treatment is submitted to us at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, we will make a determination within 24 hours of receipt of the request and we will provide coverage for the inpatient substance use disorder treatment while our determination is pending.

Retrospective Reviews

A retrospective review is the review of a request for services already rendered. If we have all the information necessary to make a determination regarding a retrospective claim, we will make a determination and notify the patient within 30 calendar days of the receipt of the request. If we need additional information, we will request it within 30 calendar days. The patient or the patient's provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to the patient in writing within 15 calendar days of the earlier of our receipt of the information or the end of the 45-day period but no longer than 45 days from the date of the request

Once we have all the information to make a decision, our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal appeal.

Retrospective Review of Preauthorized Services

We may only reverse a preauthorized treatment, service, or procedure on retrospective review when:

- The relevant medical information presented to us upon retrospective review is materially different from the information presented during the preauthorization review; and,
- The relevant medical information presented to us upon retrospective review existed at the time of the preauthorization but was withheld or not made available to us; and,
- We were not aware of the existence of such information at the time of the preauthorization review; and;
- Had we been aware of such information, the treatment, service, or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria, or procedures as used during the preauthorization review.

Reconsideration

If we did not attempt to consult with the patient's provider who recommended the covered service before making an adverse determination, the provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to the patient and the patient's provider, by telephone and in writing.

Utilization Review Internal Appeals

The patient, the patient's designee, and, in retrospective review cases, the patient's provider, may request an internal appeal of an adverse determination, either by phone, in person, or in writing.

The patient has up to 180 calendar days from the date of the notice of the adverse determination to file an appeal. We will acknowledge the patient's request for an internal appeal within 15 calendar days of receipt. This acknowledgment will, if necessary, inform the patient of any additional information needed before a decision can be made. A clinical peer reviewer who is a physician or a health care professional in the same or similar specialty as the provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the appeal.

Table 1. NCQA extension time frames for completion of authorization requests lacking necessary information (including behavioral health and non-behavioral health UM)

Type of Request	Frequency	Decision and Electronic/Written Notification Extension Time Frame (additional information needed)
Lack of necessary information or matters beyond control of Anthem		
Urgent, Concurrent	Once • Request not made at least 24 hours to expiration • Request to approve additional days for urgent, concurrent care is related to care not previously approved, and at least one attempt was made to obtain additional info within initial 24 hours of request • Member voluntarily agrees to extend the decision-making time frame	Within 72 hours from receipt of request
Urgent, Preservice	Once • Must give written notification within 24 hours of what specific information is needed • Must give 48 hours to provide the information	Within 48 hours of receiving the information or within 48 hours of the expiration of the specified time period to provide the information
Nonurgent, Preservice	Once Request must be made in writing within 3 business days from the date of request.	Within 15 calendar days of receiving information
Post service/Retrospective	Once Request must be made in writing within 3 business days from the date of request.	Within 15 calendar days of receiving information

Adverse Determinations/Reconsideration/Peer-to-Peer/Appeals

Adverse Determination

An adverse determination is the denial of a service authorization request or the approval of a service authorization request in an amount, duration, or scope that is less than what was requested. Adverse determination decisions are made by a clinical peer reviewer. Written

notice of an initial adverse determination will be sent to the member and provider and will include:

- A description of the action taken or to be taken
- The reason for the decision, including any clinical rationale

The member's right to file an internal appeal including a statement that Anthem will not retaliate or take discriminatory action against a member if an appeal is filed and a statement that the member has the right to designate someone to file an appeal on their behalf

The process and timeframe for filing an appeal, including an explanation that an expedited review can be requested

A description of what additional information, if any, must be obtained by Anthem in order to make a decision on an appeal

The timeframes, including possible extensions of when the appeal decision must be made

- Notice of the availability, upon request by the member or member's designee to obtain the review criteria or benefit provision used to make the decision

Specification of what, if any, additional information must be provided to or obtained by Anthem to make a decision on an appeal

Appeals will be reviewed by a person not involved in the initial determination

- The member's right to contact the NYSDOH at **800-206-8125** to file a complaint at any time
- Statement that the notice is available in other languages and formats for special needs and how to access these formats

Reconsideration

Reconsideration of an adverse determination can be made when a decision is made without provider input. The reconsideration will occur within one business day of receipt of the request and shall be conducted by the member's healthcare provider and the clinical peer reviewer who made the initial decision. Reconsiderations cannot be made for retrospective services.

Peer-to-Peer Review

If a request for authorization results in an adverse determination, the servicing/treating provider may discuss the decision with the physician reviewer. To arrange such a review, providers can call **800-450-8753** within seven business days of the date of the notice of determination.

Appeals

A member, a member's designee, or provider has 180 calendar days from the date of the notice of action to file an internal appeal. Providers filing appeals on behalf of the member must provide written consent from the member to act on their behalf. In cases of retrospective services, a provider may file an appeal on their own behalf. Providers filing appeals on their own behalf does not exhaust the member's right to appeal. A member

appeal may be filed verbally by calling Member Services at **800-300-8181**, or in writing to:

Medical Appeals
P.O. Box 62429
Virginia Beach, VA 23466-2429

Provider appeals maybe filed verbally by calling their Provider Representative, or in writing or through Availity Essentials.

Appeals of adverse determinations may be processed under expedited or standard time frames. The time frame for Anthem to make an appeal decision begins when Anthem receives the necessary information. The clinical peer reviewer for all appeal reviews will not be the same clinical peer reviewer who made the initial decision. Anthem will send a written acknowledgment of the appeal within fifteen (15) calendar days of receipt of the appeal request. If a decision is made before the written acknowledgment is sent, the written acknowledgment may be included with the notice of appeal determination. Members will be given the opportunity to present evidence both before and during the appeal process and will be allowed to examine their case file and receive a free copy of their case file upon request.

Expedited Review and Timeframes
An appeal will automatically be processed as expedited if any of the following types of denials are issued:

- Denial for concurrent services or denial of an extension for concurrent services
- Denial of a hospital admission while the member is still in-house at the time of the denial
- Denial of home care services following admission to the hospital

Denial of services that the member or member's physician feels are urgent, and a delay in review would jeopardize the member's life, health or the ability to attain, maintain, or regain maximum function

Members have the right to request an expedited appeal, but Anthem may deny and notify the member immediately by phone, and in writing within two (2) days of the decision to deny an expedited review request, that the appeal will be processed under standard appeal time frames. If Anthem requires additional information to process the appeal, Anthem will immediately notify the member and the member's healthcare provider by phone or fax, followed by a written notice.

An expedited appeal decision will be made as fast as the member's condition requires and within two (2) business days of receipt of the necessary information but no more than 72 hours after receipt of the appeal. A member may be eligible to file an external expedited appeal at the same time. Expedited appeals not resolved to the satisfaction of the appealing party may be reappealed via an external appeal process. For an expedited

appeal, providers will have reasonable access to the clinical peer reviewer assigned to the appeal within one (1) business day of receipt of the request for an appeal. Providers and clinical peer reviewers may exchange information by telephone or fax. Written notification of an expedited appeal decision will be sent within 24 hours of rendering the decision. Anthem will make a reasonable effort to provide oral notice to the member and the provider at the time the decision is made.

Standard Review and Timeframes
A standard appeal decision will be made as fast as the member's condition requires but no later than 30 days from receipt of the appeal.

If Anthem requires additional information to process the appeal, Anthem will notify the member and the member's healthcare provider, in writing, within 15 days of receipt of the appeal of the need for additional information. In the case that only a portion of the necessary information is received, Anthem will request the missing information, in writing, within five business days of receipt of the partial information. Turnaround time for an appeal decision, whether expedited or standard, may be extended for up to 14 days when the member, member's designee, or provider requests an extension; or Anthem can demonstrate a need for more information and the extension is in the member's best interest. An extension notification will be mailed to the member.

Written Notification of Appeal Decisions
Written notification of an appeal decision will be sent to the member, member's designee, and provider within two business days of rendering the decision. If the provider appealed on their own behalf written notification of the appeal decision will be sent to the provider only within two business days of rendering the decision. The written notification will include:

- The date, basis, and clinical rationale for the decision
- The words "final adverse determination"
- The Anthem contact person and phone number
- The member's coverage type
- The UR agent's name, address, contact person, and phone number
- The service that was denied, including facility/provider and developer/manufacturer of service as available

A statement that the member may be eligible for an external appeal and the time frames for an external appeal

- The standard description of the external appeal process
- A summary of the appeal and date filed
- The date the appeal process was completed
- The member's right to contact the NYSDOH at **800-206-8125** and complain
- A statement that the notice is available in other languages and formats for special needs and how to access these formats

Failure to make an appeal decision within the time frames noted above is deemed to be a reversal (approval) of the adverse determination. Anthem and the member may jointly agree to waive the internal appeal process. If this occurs, Anthem will inform the member of the process to request an external appeal in writing within 24 hours of the agreement to waive the internal appeal process.

To comply with both NYS regulatory requirements and NCQA standards, Anthem will follow the most stringent time frames for appeals.

Medically Necessary
Medically necessary health services are defined as health services that meet all or one of the following conditions:

- Services are essential to prevent, diagnose, prevent the worsening of, alleviate, correct or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, result in illness or infirmity of a member or interfere with such person's capacity for normal activity.

Services are provided at an appropriate facility and at the appropriate level of care for the treatment of the member's medical condition.
Services are provided in accordance with generally accepted standards of medical practice.

Note: We do *not* cover the use of any experimental procedures or experimental medications, except under certain preauthorized circumstances.

8 CLAIM SUBMISSION AND ADJUDICATION PROCEDURES

Claims Submission Overview

All claims must be submitted in accordance with the requirements of the provider contract, and this Provider Manual. You may not seek payment for covered services from the member, except for any applicable visit fees, co-payments, deductibles, coinsurance, or penalties as described in the member's contract.

To facilitate claims processing, all claims must
Be submitted within 120 calendar days of the date of service

- Include the member's name, ID number, and plan prefix — exactly as it appears on the ID card include the member's relation code
- Include the member's date of birth
- Include the physician's or practitioner's name and NPI number for the plan include the physician's or practitioner's tax ID number

All providers who participate in an Anthem network must have a National Provider Identification (NPI) number. All NPI numbers must be registered with Anthem.

Timely filing is within 120 days from the date of service or per the terms of the provider agreement.

Anthem provides an online resource designed to significantly reduce the time your office spends verifying eligibility, claims status, and authorization status. Log in to our website and browse through the Tools section for more details.

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).

What is ICD-10?

International Classification of Diseases, 10th Revision (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; and 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 two parts to ICD-10:

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

ICD-10-CM replaced the code sets, ICD-9-CM, Volumes 1 and 2 for diagnosis coding, and ICD-10-PCS will replace ICD-9-CM, Volume 3 for inpatient hospital procedure coding.

Coding Claims

To facilitate efficient claims processing, the appropriate, valid procedure and diagnosis codes consistent with the member's age and gender should be submitted on claims. CPT and HCPCS modifiers assist in clarifying services and determining reimbursement. Claims reporting incompatible procedures, diagnoses, and modifiers may be denied. Likewise, if an unlisted or non-descript procedure code is billed electronically, (code ending in "99") the claim will be denied. If a denial is received due to a non-descript or unlisted CPT or HCPCS code was billed, a paper claim with Medical Records attached may be submitted for consideration or the appeal process may be evoked to review the original denial.

Provider and Facility Digital Guidelines

Anthem understands that working together digitally streamlines processes and optimizes efficiency. We developed the Provider and Facility Digital Guidelines to outline our expectations and to fully inform providers and facilities about our digital platforms.

Anthem expects providers and facilities will utilize digital tools unless otherwise prohibited by law or other legal requirements.

Digital guidelines establish the standards for using secure digital provider platforms (websites) and applications when transacting business with Anthem. These platforms and applications are accessible to both participating and nonparticipating providers and facilities and encompass Availity.com, electronic data interchange (EDI), electronic medical records (EMR) connections, and business-to-business (B2B) desktop integration.

The Digital Guidelines outline the digital/electronic platforms Anthem has available to participating and nonparticipating providers and facilities who serve its members. The expectation of Anthem is based on our contractual agreement that providers and Facilities will use these digital platforms and applications unless otherwise mandated by law or other legal requirements.

Digital and/or electronic transaction applications are accessed through these platforms:

- Availity Essentials EDI Clearinghouse
- B2B application programming interfaces (APIs)
- EMR connections

Digital guidelines available through Availity Essentials include:

- Acceptance of digital ID cards
- Eligibility and benefit inquiry and response

- Prior authorization submissions including updates, clinical attachments, authorization status, and clinical appeals
- Claim submission, including attachments, claim status
- Remittances and payments
- Provider enrollment
- Demographic updates

Additional digital applications available to providers and facilities include:

- Pharmacy prior authorization drug requests

Services through Carelon Medical Benefits Management, Inc.
Services through Carelon Behavioral Health, Inc.

Anthem expects providers and facilities transacting any functions and processes above will use available digital and/or electronic self-service applications in lieu of manual channels (paper, mail, fax, call, chat, etc.). All channels are consistent with industry standards. All EDI transactions use version 5010.

Note: As a mandatory requirement, all trading partners must currently transmit directly to the Availity Essntials EDI gateway and have an active Availity Essentials Trading Partner Agreement in place. This includes providers using their practice management software & clearinghouse billing vendors.

Providers and facilities who do not transition to digital applications may experience delays when using non-digital methods such as mail, phone, and fax for transactions that can be conducted using digital applications.

Availity Essentials
Availity Essentials is an online multi-payer portal that gives physicians, hospitals, and other healthcare professionals access to multiple payer information with a single, secure sign-on.

The Availity Essentials web portal offers the following transactions for Anthem providers:

- Eligibility and benefits inquiries
- Claim status inquiries
- Claim submissions
- Claim Disputes
- Medical Attachments
- Prior Authorizations and Referrals

If your office is not registered to use Availity Essentials, please register at Availity.com today so you and your staff can have immediate access to the online tools. Select the **Get Started** button under *Register Now for the Availity Essentials*, and then complete the online registration wizard.

If you have questions about Availity Essentials or need assistance with registration, contact Availity Client Services at **800-Availity (800-282-4548)** or email questions to support@availity.com.

Get Trained
Visit the Provider Learning Hub to view training guides and on-demand demos for Availity Essentials functionality. (https://rebrand.ly/104185)

Section 1: Accepting digital ID cards
As our members transition to digital Member ID cards, providers and facilities may need to implement changes in their processes to accept this new format. Anthem expects that providers and facilities will accept the digital version of the member identification card in lieu of a physical card when presented. If providers and facilities require a copy of a physical ID card, members can email a copy of their digital card from their smartphone application, or providers and facilities may access it directly from Availity Essentials through the Eligibility and Benefits Inquiry application.

Section 2: Eligibility and benefits inquiry and response
Providers and facilities should leverage these Availity Essentials Clearinghouse hosted channels for electronic eligibility and benefit inquiry and response:

- EDI transaction: X12 270/271 – eligibility inquiry and response
  - Anthem supports the industry standard X12 270/271 transaction set for eligibility and benefit inquiry and response as mandated by HIPAA.
- Availity Essentials
  - The Eligibility and Benefits Inquiry verification application located under Patient Registration allows a provider and facility 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 EMR software. Contact Availity Essentials for available vendor integration opportunities.

Section 3: Prior authorization submission, attachment, status, and clinical appeals.
Providers and facilities should leverage these channels for prior authorization submission, status inquiries and to submit electronic attachments related to prior authorization submissions:

- EDI transaction: X12 278 – prior authorization and referral:
  - 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 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.

- Availity Essentials:
  - Authorization applications include the Availity Essentials multi-payer Authorization and Referral application located under Patient Registration.
    - Availity Essentials Authorization application enables prior authorization submission, authorization status inquiry, and the ability to review previously submitted authorizations.
- 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 EMR software. Contact Availity Essentials for available vendor integration.

Section 4: Claims: submissions, claims payment disputes, attachments, and status

Claim submissions status and claims payment disputes

Providers and facilities should leverage these channels for electronic Claim submission, attachments (for both pre- and post-payment), and status:

- 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.
  - 837 Claim batch upload through EDI allows a provider to upload a batch/file of Claims (must be in X12 837 standard format).

Using Availity Essentials

EDI Payer IDs:

- Professional - 00803
- Institutional - 00303

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

Availity Essentials EDI submission options:

- Use existing clearinghouse or billing vendor:
  - Work with your vendor to ensure connection to the Availity Essentials EDI Gateway.
- Become a direct submitter with the Availity Essentials EDI Clearinghouse:
  - A third-party practice or revenue cycle management system capable of generating EDI batch files is required.
- EDI transaction: X12 276/277 – Claim status inquiry and response:

— Anthem supports the industry-standard X12 276/277 transaction set for Claim status inquiry and response as mandated by HIPAA.

Availity Essentials: The online claims application located under Claims & Payments enables a provider to enter a Claim directly into an online Claim form and upload supporting documentation for a defined Claim.

— The Claim Status application located under Claims & Payments enables a provider to access online Claim status. Access the Claim Appeals tool under Claims & Payments by first initiating a dispute from the Claim Status application. Once a dispute is initiated, navigate to the Appeals Application to upload documents and complete the dispute request. Anthem expects that electronic Claim payment disputes be adopted when and where it is integrated.

- 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 EMR software. Contact Availity Essentials for available vendor integration.

Claim attachments

Providers and facilities should leverage these channels for electronic Claim attachments from Availity.com:

- EDI transaction: X12 275 – Patient information, including HL7 payload attachment:

— Anthem supports the industry standard X12 275 transaction for electronic transmission of supporting Claim documentation including medical records via the HL7 payload.

Availity Essentials – Claim Status application enables a provider or facility to digitally submit supporting claims documentation, including medical records, directly to the Claim:

— Digital Request for Additional Information (Digital RFAI) – The Medical Attachments application under the Claims & Payment menu on Availity Essentials enables the transmission of digital notifications when additional documentation including medical records are needed to process a Claim.

Section 5: Electronic remittance advice and electronic claims payment

Electronic remittance advice:

- Electronic remittance advice (ERA) is an electronic data interchange (EDI) transaction of the explanation of payment of your claims. Anthem supports the industry-standard X12 835 transaction as mandated per HIPAA.
- Providers and facilities can register, enroll, and manage ERA preference through Availity.com. Printing and mailing remittances will automatically stop thirty (30) days after the ERA enrollment date:

— Viewing an ERA on Availity Essentials is under Claims & Payments, Remittance Viewer. Features of remittance viewer, include the ability to search a two (2) year history of remittances and access the paper image.

- Viewing a portable document format (PDF) version of a remit is under Payer Spaces which provides a downloadable PDF of the remittance.

To stop receiving ERAs for your claims, contact Availity Essentials Client Services at **800-AVAILITY** (**282-4548**).

To re-enable receiving paper remittances, contact Provider Services.

Electronic claims payment

Electronic claims payment is a secure and fast way to receive payment, reducing administrative processes. There are several options to receive claims payments electronically:

- Electronic Funds Transfer (EFT):
  - Electronic funds transfer (EFT) uses the automated clearinghouse (ACH) network to transmit healthcare payments from a health plan to a provider's or facility's bank account at no charge for the deposit. Health plans can use a provider's or facility's banking information only to deposit funds, not to withdraw funds. The EFT deposit is assigned a trace number (TRN) to help match the payment to the correct 835 electronic remittance advice (ERA), a process called reassociation.
  - **To enroll in EFT:** Providers and facilities can register, enroll, and manage account changes for EFT through EnrollSafe at **enrollsafe.payeehub.org**. EnrollSafe enrollment eliminates the need for paper registration. EFT payments are deposited faster and are generally the lowest-cost payment method. For help with enrollment, **use this convenient EnrollSafe User Reference Manual**.
  - **To disenroll from EFT:** Providers and facilities are entitled to disenroll from EFT. Disenroll from EFT payments through EnrollSafe at **enrollsafe.payeehub.org**.
- Virtual Credit Card (VCC):
  - For providers and facilities who don't enroll in EFT, and in lieu of paper checks, Anthem is shifting some reimbursements to virtual credit cards (VCC). VCC allows providers and facilities to process payments as credit card transactions. Check with your merchant processor regarding standard transaction fees that will apply.
  - Note that Anthem may receive revenue for issuing a VCC.
  - **Opting out of virtual credit card payment**. Providers and facilities are entitled to opt out of electronic payment. To opt out of virtual credit card payment, there are two (2) options:
    - Enrolling for EFT payments automatically opts you out of virtual credit card payments. To receive EFT payments instead of virtual credit card payments, enroll for EFT through EnrollSafe at **enrollsafe.payeehub.org**.
      OR
    - To opt out of virtual credit card payments, contact Comdata at **800-833-7130** and provide your taxpayer identification number.
- Zelis Payment Network (ZPN) electronic payment and remittance combination:

- The Zelis Payment Network (ZPN) is an option for providers and facilities looking for the additional services Zelis can offer. Electronic payment (ACH or VCC) and Electronic Remittance Advice (ERA) via the Zelis portal are included together with additional services. For more information, go to Zelis.com. Zelis may charge fees for their services.
- Note that Anthem may receive revenue for issuing ZPN.
- ERA through Availity Essentials is not available for providers and facilities using ZPN.
- **To disenroll from ZPN payment,** there are two (2) options:
  - Enrolling for EFT payments automatically removes you from ZPN payments. To receive EFT payments instead of ZPN payments, enroll for EFT through EnrollSafe at enrollsafe.payeehub.org.
    OR
  - To disenroll from ZPN payments, update your Zelis registration on the Zelis provider portal or contact Zelis at **877-828-8770**.

Not being enrolled for EFT, VCC, or ZPN will result in paper checks being mailed.

Verification of Benefits

Benefits can be verified by calling Anthem Provider Services at **800-450-8753**, Monday through Friday, 8:30 a.m. to 5 p.m.

Providers should keep a photocopy of the member's ID card (front and back) on file and ask the member if coverage has changed upon each visit. Please refer to **Chapter 4** of this provider manual for a sample ID card.

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

Paper Claims Submission

Submitting claims electronically through Availity Essentials is the quickest way to get your claims processed. You also have the option of submitting paper claims. We use Optical Character Reading (OCR) technology as part of our front-end claims processing procedures. The benefits include:

- Faster turnaround times and adjudication
- Claims status availability within five days of receipt

Immediate image retrieval by our staff for claims information, allowing more timely and accurate responses to your inquiries

To use OCR technology, claims must be submitted on original red claim forms (not black and white or photocopied forms), laser printed or typed (not handwritten), and in a large, dark font. You must submit a properly completed UB-04 or CMS-1500 (08-05) within 120 days from the date of service.

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

- Patient's ID number
- Patient's name
- Patient's date of birth

ICD diagnosis code/revenue code

- Date of service
- Place of service
- Description of services rendered
- Itemized charges
- Days or units
- Provider tax ID number
- Provider name according to contract
- Anthem provider number
- NPI of billing provider when applicable
- CLIA Identification number when applicable (CMS-1500 only)
- COB/other insurance information
- Authorization/precertification number
- Name of referring physician
- NPI of referring physician when applicable
- 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 entirely handwritten claims.

Paper claims must be submitted within 120 days of the date of service and submitted to the following address:

Anthem Blue Cross and Blue Shield HP
New York Claims
P.O. Box 61010
Virginia Beach, VA 23466-1010

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 us encounter data for each member encounter. Encounter data can be submitted through EDI submission methods or on a CMS-1500 (08-05) claim form unless we approve other arrangements. Data will be submitted in a timely manner, but no later than 120 days from the date of service.

The encounter data will include the following:

- Member's ID number
- Member's name (first and last name)
- Member's address
- 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 (using current procedure codes and modifiers if applicable)
- Provider's tax ID number

Encounter data should be submitted to the following address:

Anthem Blue Cross and Blue Shield HP
P.O. Box 61010
Virginia Beach, VA 23466-1010

HEDIS information is collected through claims and encounter data submissions. This includes but is not limited to:

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

Compliance is monitored by our utilization 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 utilization reporting. Lack of compliance will result in training and follow-up audits and could result in termination from the network.

Encounter Data for Risk Adjustment Purposes

Commercial Risk Adjustment and Data Submission

Risk adjustment is the process used by Health and Human Services (HHS) to adjust the payment made to the Federal Exchange plans based on the health status of the exchange-covered individuals. Risk adjustment was implemented to pay health plans participating in exchanges more accurately for the predicted health cost expenditures of covered individuals by adjusting payments based on demographics (age and gender) as well as health status. Anthem, as an Exchange Participating Organization (EPO) defined by HHS, is required to submit diagnosis data collected from encounters and claim data to HHS for purposes of risk adjustment. Because HHS requires that EPOs submit "all ICD-10 or successor codes for each beneficiary," Anthem also collects diagnosis data from the covered individuals' medical records created and maintained by the provider or facility.

Under the HHS risk adjustment model, the EPO is permitted to submit diagnosis data from inpatient hospitals, outpatient hospitals, and physician encounters only.

Billing Policy and Procedure

Overview

All claims must be submitted in accordance with the requirements of the provider contract, applicable member's contract, and this provider manual. You may not seek payment for covered services from the member, except for any applicable visit fees, co-payments, deductibles, coinsurance, or penalties as described in the member's contract. Except for co-payments, which may be collected at the time of service or discharge, you should not bill the member for any cost-sharing amounts until they have received an explanation of benefits (EOB). In no event should you require a deposit from a member prior to providing covered services to the member. Any administrative charges applied by physicians must be within Anthem's contractual and policies guidelines and should be prominently displayed within the office and disclosed to members prior to any services being rendered.

Billing Members

Overview

Before rendering services, always inform members that the cost of services not covered by us will be charged to the member.

If you choose to provide services, we ***do not cover:***

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

Our members must not be balance-billed or billed for the amount above that which we allow for covered services.

In addition, you may ***not*** bill a member if any of the following occurs:
Failure to timely submit a claim, including claims we don't receive
Failure to submit a claim to us for initial processing within the 120-day filing deadline
Failure to submit a corrected claim within the 120-day filing resubmission period

- Failure to appeal a claim within the 45-day administrative appeal period
- Failure to appeal a UR determination within 60 business days of notification of coverage denial
- Submission of an unsigned or otherwise incomplete claim

- Errors made in claims preparation, claims submission, or the appeal process

Client Acknowledgment Statement

You may bill an Anthem 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

You obtain and keep a written acknowledgement statement signed by you and the member stating:

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

Co-payments and Cost-Sharing

Members are responsible for the co-payment amount indicated on their ID cards. Co-payments apply to home and office visits but do not apply to in-network annual preventative care visits or maternity care. There may be exceptions depending on the member's contract.

Co-payments may be collected at the time of the patient's visit. Coinsurance and deductibles must be collected from members after you receive the explanation of payments (EOP).

Per the Anthem Practitioner Agreement, a physician or practitioner agrees to only seek payment from a member for a health service that is not covered under the member's benefit plan, whether it is not covered because it is specifically excluded, is not considered medically necessary or is considered investigational, when the physician or practitioner has obtained a signed Anthem Client Acknowledgment Statement.

Claims Adjudication

We're dedicated to providing timely adjudication of your 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 and ICD manuals. Institutional claims should be submitted using EDI submission methods or a UB-04 CMS-1450, and professional services using the CMS-1500.

Use HIPAA-compliant billing codes when billing us. This applies to both electronic and paper claims. When billing codes are updated, you're required to use appropriate replacement codes for submitted claims. Anthem won't pay any claims submitted using non-compliant billing codes.

We reserve 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, adhere to the following time limits:
Submit claims within 120 days from the date the service is rendered or for inpatient claims filed by a hospital within 120 days from the date of discharge. Claims submitted after the 120-day filing deadline will be denied

After filing a claim with us, review the weekly Explanation of Payment (EOP). If the claim does not appear on an EOP within 30 business days as adjudicated or you have no other written indication that the claim has been received, check the status of your claim on our website or by calling Provider Services at **800-450-8753**. If the claim is not on file with us, resubmit your claim within 120 days from the date of service. If filing electronically, check the confirmation reports that you receive from your EDI or practice management vendor for acceptance of the claim.

Clean Claims Payment
A clean claim is a request for payment for a service rendered by a provider that:
Is submitted timely.
Is accurate.
Is submitted on a HIPAA-compliant standard claim form (CMS-1500 or CMS-1450), or successor forms thereto, or the electronic equivalent of such claim form.
Requires no further information, adjustment, or alteration by a provider or by a third party in order for us to process and pay it.

We adjudicate all clean electronic claims within 30 days and all clean paper claims within 45 calendar days of receipt of a clean claim. If we don't adjudicate the clean claim within the time frame specified above, we'll pay all applicable interest as required by law.

Biweekly, we produce and mail to you an EOP, which delineates the status of each of your claims that have been adjudicated during the previous check week cycle. Upon receipt of the requested information from you, we attempt to complete the processing of the clean claims; contractually, we have 30 days for electronic claims and 45 days for paper claims.

Paper claims determined to be unclean will be returned to you along with a letter stating the reason for the rejection. Electronic claims that are determined to be unclean will be returned to our contracted clearinghouse that submitted the claim.

In accordance with state insurance requirements, except in a case where our obligation to pay is not reasonably clear or when there is a reasonable basis that the claim was submitted fraudulently, we'll pay the electronic claim within 30 days or paper claims within 45 days of the date of receipt. In a case where our obligation to pay a claim is not reasonably clear, we'll pay any undisputed portion of the claim and notify you in writing within the appropriate time frame above that we:
Are not obligated to pay the claim, stating the specific reasons why we are not liable.
Need additional information to determine liability to pay the claim or make the payment.

Claims Status

Log in to our website or call **800-450-8753** to check claims status.

Reimbursement
Electronic Funds Transfer and Electronic Remittance Advice
We offer Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) with online viewing capability. You can elect to receive Anthem payments electronically through direct deposit to your bank accounts. In addition, you can select from a variety of remittance information options, including:

- Electronic remittance advice presented online and printed in your location
- HIPAA-compliant data files for download directly to your practice management or patient accounting system
- Paper remittance we print and mail to you

Some of the benefits providers may experience include:

- Faster receipt of payments from us
- The ability to generate custom reports on both payment and claim information based on the criteria specified
- Online capability to search claims and remittance details across multiple remittances
- Elimination of the need for manual entry of remittance information and user errors
- Ability to perform faster secondary billing

To register for ERA/EFT, please visit our website.

PCP Reimbursement
We reimburse PCPs according to their contractual arrangement.

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

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

Specialty care provider services will be covered only when there is documentation of appropriate notification or precertification, as appropriate, and receipt of the required claims and encounter information to us.

Reimbursement Policies

Reimbursement policies serve as a guide to assist you in accurate claims 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 certain 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 Procedural Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or Revenue codes which indicate the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

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

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

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

Reimbursement Hierarchy

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

Review Schedules and Updates to Reimbursement Policies

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

Reimbursement by code definition

Anthem allows reimbursement for covered services based on their procedure code definitions or descriptors unless otherwise noted by state or provider contracts, or state, federal, or CMS requirements.

There are eight CPT sections:

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

Documentation Standards for an Episode of Care

Anthem requires that upon request for clinical documentation to support claims payment for services, the information provided should:
Identify the member.

- Be legible.
- Reflect all aspects of care.

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

- Consent forms
- Health history, including applicable drug allergies
- Physical examinations
- Diagnoses and treatment plans for individual episodes of care
- Physician orders
- Face-to-face evaluations, when applicable
- Progress notes
- Referrals, when applicable

- Consultation reports, when applicable
- Laboratory reports, when applicable
- Imaging reports (including x-ray), when applicable
- Surgical reports, when applicable
- Admission and discharge dates and instructions, when applicable

Preventive services provided or offered, appropriate to member's age and health status

- Evidence of coordination of care between primary and specialty physicians, when applicable

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

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

- Legible to someone other than the writer

Information identifying the member must be included on each page in the medical record

- Each entry in the medical record must be dated and include author identification, which may be a handwritten signature, unique electronic identifier, or initials

Other documentation not directly related to the member

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

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

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

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

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

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, Blood Products and Administration

Blood and blood products such as platelets or plasma are reimbursable. Administration of Blood or Blood Products by nursing/facility personnel are not separately reimbursable on inpatient claims. Administration of Blood or Blood Products by nursing/facility personnel billed on outpatient claims is separately reimbursable when submitted without observation/treatment room charges.

Charges for blood storage, transportation, processing, and preparation such as thawing, splitting, pooling, and irradiation are also not separately reimbursable. Lab tests such as typing, Rh, matching, etc., are separately reimbursable charges.

Emergency Room Supplies and Services Charges

The Emergency Room level reimbursement includes all monitoring, equipment, supply, 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 or procedure charge. 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), 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 and are included in the reimbursement 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, are not separately reimbursable and are included as part of the Operating Room (OR) time/procedure reimbursement. Charges for medications/drugs used for 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, handling, and referral fees are considered included in the procedure/lab test performed and are 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, nasogastric tube ("NGT") insertion, urinary catheter insertion, point of care/bedside testing (such as glucose, blood count, arterial blood gas, clotting time, pulse oximetry, etc.) and inpatient blood transfusion administration/monitoring (with the exception of OP blood administration, OP chemotherapy administration, or OP infusion administration which are submitted without a room charge, observation charges, treatment room charges, or procedure charges other than blood, chemotherapy, or infusion administration.)

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 is defined as surgical suites, major and minor, treatment rooms, endoscopy labs, cardiac cath labs, Hybrid Rooms, X-ray, pulmonary and cardiology procedural rooms. The operating room charge will reflect the cost of:

- The use of the operating room
- The services of qualified professional and technical personnel
- Any supplies, items, equipment, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services. Refer to Routine Supplies section of the manual.

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, eye lubricants, lotion, non-medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, toothbrush and toothpaste.

Pharmacy Charges

Pharmacy charges will be reimbursed to include only the cost of the drugs prescribed by the attending physician. Medications furnished to patients shall not include an additional separate charge for 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. All other services are included in the drug reimbursement rate. Examples 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. Reimbursement for the procedure includes all nursing care provided.

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 all used and/or available services, equipment, monitoring, and nursing care that is necessary for the patient's welfare and safety during their 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 or step-down recovery room (e.g., arteriograms).

Respiratory Services

Mechanical ventilation/CPAP/BIPAP support and other respiratory and pulmonary function services provided at the bedside are considered facility personnel, equipment, and/or supply charges and not eligible for separate reimbursement.

Routine Supplies

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 supplies and not separately reimbursable in the inpatient and outpatient

environments. Reimbursement for routine services and supplies is included in the reimbursement for the room, procedure, or observation charges.

Special Procedure Room Charge

Charges for Special procedure room, billed in addition to the procedure itself, are included in the reimbursement for the procedure. If the procedure takes place outside of the OR (Refer to Operating Room Time and Procedure Charges for OR definition), then OR time will not be reimbursed to cover OR personnel/staff being present in the room. Example: procedures performed in the ICU, ER, etc.

Stand-by Charges

Standby equipment and consumable items such as oxygen, which are on standby, are not reimbursable. Only actual use is covered. 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, isolation carts, mechanical ventilators, continuous positive airway pressure (CPAP)/ bilevel positive airway pressure (BIPAP) machines, and related supplies are not separately reimbursable. Oxygen charges, including but not limited to, oxygen therapy per minute/per hour when billed with room types ICU/CCU/NICU or any Specialty Care area are not separately reimbursable.

Tech Support Charges

Pharmacy Administrative Fees (including mixing medications), any portable fees for a procedure or service, patient transportation fees when taking a patient to an area for a procedure or test are not separately reimbursable. Transporting a patient back to their room following surgery, a procedure, or test, 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.

Undocumented or Unsupported Charges

Charges that are not documented on medical records or supported with documentation are not reimbursed.

Video or Digital Equipment used in Procedures

Charges for video or digital equipment used for visual enhancement during a procedure are included in the reimbursement for the procedure and are not separately reimbursable. Examples include but are not limited to Ultrasound and Fluoroscopy guidance. Charges for batteries, covers, film, anti-fogger solution, tapes etc., are also not separately reimbursable.

Additional Reimbursement Guidelines for Disallowed Charges

For any claims that are reimbursed at a percent of charge, only Charges for Covered Services are eligible for reimbursement. 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 the Provider or Facility Agreement. Refer to the contractual fee schedule for payment determination.

Examples of non-reimbursable items/services codes (including but not limited to):	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0990 – 0999	**Personal Care Items** • Courtesy/Hospitality Room • Patient Convenience Items (0990) • Cafeteria, Guest Tray (0991) • Private Linen Service (0992) • Telephone, Telegraph (0993) • TV, Radio (0994)

	• Non-patient Room Rentals (0995) • Beauty Shop, Barber (0998) • Other Patient Convenience Items (0999)
0220	Special Charges
0369	Preoperative Care or Holding Room Charges
0760 – 0769	Special Procedure Room Charge
0111 – 0119	Private Room* (subject to Member's Benefit)
0221	Admission Charge
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) Stand-by Charges
0220, 0949	Stat Charges
0270 – 0279, 0360	Video or Digital Equipment Used in Procedures
0270, 0271, 0272	**Supplies and Equipment** • Blood Pressure cuffs/Stethoscopes • Thermometers, Temperature Probes, etc. • Pacing Cables/Wires/Probes **Supplies and Equipment (continued)** • Pressure/Pump Transducers • Transducer Kits/Packs • SCD Sleeves/Compression Sleeves/Ted Hose • Oximeter Sensors/Probes/Covers • Electrodes, Electrode Cables/Wires • Oral swabs/toothettes; • Wipes (baby, cleansing, etc.) • Bedpans/Urinals • Bed Scales/Alarms • Specialty Beds • Foley/Straight Catheters, Urometers/Leg Bags/Tubing • Specimen traps/containers/kits • Tourniquets • Syringes/Needles/Lancets/Butterflies • Isolation carts/supplies • Dressing Change Trays/Packs/Kits • Dressings/Gauze/Sponges

	• Kerlix/Tegaderm/OpSite/Telfa • Skin cleansers/preps • Cotton Balls; Band-Aids, Tape, Q-Tips • Diapers/Chucks/Pads/Briefs • Irrigation Solution **Supplies and Equipment (continued)** • 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, sets, transducers, fluid warmers, heparin, and saline flushes, etc.)
0220 – 0222, 0229, 0250	**Tech Support Charges** • 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 and 99001 – Handling and/or conveyance of specimen from patient (charge for specimen handling
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** • Medication prep • Nonspecific descriptions **Pharmacy (continued)** • Anesthesia Gases – Billed in conjunction with Anesthesia Time Charges • IV Solutions 250 cc or less, except for pediatric claims • Miscellaneous Descriptions • Compounding fees
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	**Venipuncture** • Specimen collection • Draw fees • Venipuncture • Phlebotomy • Heel stick • Blood storage and processing blood administration • Thawing/Pooling Fees

0270, 0272, 0300 – 0309	• Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time, etc.)
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0410, 0460	**Supplies and Equipment** • Oxygen • Instrument Trays and/or Surgical Packs • Drills/Saws (All power equipment used in O.R.) • Drill Bits **Supplies and Equipment (continued)** • Blades • IV pumps and PCA (Patient Controlled Analgesia) pumps • Isolation supplies • Daily Floor Supply Charges • X-ray Aprons/Shields • Blood Pressure Monitor • Beds/Mattress • Patient Lifts/Slings • Restraints • Transfer Belt • Bair Hugger Machine/Blankets • SCD Pumps • Heel/Elbow Protector • Burrs • Cardiac Monitor • EKG Electrodes • Vent Circuit • Suction Supplies for Vent Patient • Electrocautery Grounding Pad • Bovie Tips/Electrodes • Anesthesia Supplies • Case Carts • C-Arm/Fluoroscopic Charge **Supplies and Equipment (continued)** • Wound Vacuum Pump • Bovie/Electro Cautery Unit • Wall Suction • Retractors • Single Instruments • Oximeter Monitor

	• CPM Machines • Lasers • Da Vinci Machine/Robot
0370 – 0379, 0410, 0460, 0480 – 0489	Anesthesia (Specifically, conscious/moderate sedation by same physician or procedure nurse) • Nursing care • Monitoring • Intervention • Pre- or Post-evaluation and education • IV sedation and local anesthesia if provided by same physician or procedure nurse • Intubation/Extubation • CPR

0410	Nursing Respiratory Functions • Oximetry • Vent management • Medication Administration via Nebs, Metered dose (MDI), etc • Postural Drainage • Suctioning Procedure
0940 – 0945	Education/Training

Overpayment Process

Refund notifications may be identified by two entities, Anthem Cost Containment Unit (CCU) or the provider. The CCU 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, CCU will notify the provider of the overpayment. The provider will have the option to submit a *Refund Notification Form* along with the refund check or have the overpayment offset from future claim payments. If a provider identifies the overpayment or returns the Anthem check, a completed *Refund Notification Form* specifying the reason for the return must be included. The claim information must be submitted with this form. This form can be found on the provider website at providers.anthem.com/ny. The submission of the *Refund Notification Form* will allow the CCU to process and reconcile the overpayment in a timely manner. If a Refund

Notification Form is not available, the provider can submit the refund check with a letter. The letter should include the following:

- Provider name/contact,
- Contact number,
- Provider ID,
- Provider Tax ID
- Subscriber ID
- Member Name
- Member Account Number
- Date of Service
- Total Billed Charges
- Total Check Amount
- Claim number(s)
- Reason for refund or check return:
  - Received an Overpayment Notification Letter
  - Contract rate change
  - Duplicate payment
  - Incorrect member
  - Incorrect provider
  - Negative Balance
  - Other Health Insurance (OHI) / Third-party liability (TPL)
  - Payment error
  - Billed in error / adjusted charge
  - Or other reason

In instances where we are required to adjust previously paid claims to adhere to a newly 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 that 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.

For questions regarding the refund notification procedure, please call **800-450-8753** and select the appropriate prompt. Changes addressing the topic of overpayments have taken place with the passage of the Patient Protection and Affordable Care Act (PPACA), commonly known as the Healthcare Reform Act.

Cost Containment Overpayment Disputes

As indicated in the Anthem refund request letter, provider overpayment refunds not received and applied within the timeframe indicated will result in claim recoupment from any claim the provider submits to Anthem.

Providers wishing to submit an overpayment dispute for a solicited overpayment recoupment request can submit their request via Availity Essentials, by mail, or Fax.

The mailing address and fax number are:

Cost Containment — Disputes
PO Box 62427
Virginia Beach, VA. 23466-2437
Fax: **866-920-1874**

The processing time once these documents are received is 30 days.

Providers submitting a refund check, should mail the refund to the address below and include a copy of the overpayment letter received, a list of claims being refunded and the refund amount to be applied to each claim to:

Cost Containment
PO Box 933657
Atlanta, GA. 31193-3657

What does this mean for you?
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.

9 PROVIDER COMPLAINT PROCEDURES

Administrative issues and nonpayment-related complaints

We have a formal complaint process for the handling of disputes pertaining to administrative issues and nonpayment-related matters. You may access this process by filing a written complaint. Your complaints will be resolved fairly, consistent with our policies and covered benefits. You aren't penalized for filing complaints. Any supporting documentation should accompany the complaint.

File complaints in writing to:

Anthem Blue Cross and Blue Shield HP
Attn: Provider Relations
PENN 1, 35th FL
New York, NY 10119

Email: nyproviderinquiries@anthem.com

Provider Claim Payment Disputes

You may access a timely claim payment dispute resolution process. A claim payment dispute is any dispute between the health care provider and Anthem for reason(s) including:
Denials for timely filing
Our failure to pay timely

- Contractual payment issues
- Lost or incomplete claim forms or electronic submissions

Requests for additional explanation as to services or treatment you rendered
Inappropriate or unapproved referrals you initiated (e.g., a payment dispute may arise if you were required to get authorization for a service, did not request the authorization, provided the service, and then submitted the claim).

- Provider appeals without member's consent
- Retrospective review after a claim denial or partial payment
- Request for supporting documentation

Responses to itemized bill requests, submission of corrected claims, and submission of coordination of benefits/third-party liability information are not considered claim payment disputes. These are considered correspondence and should be addressed to Claims Correspondence.

No action is required by the member. Claim payment disputes do not include medical appeals.

You will ***not*** be penalized for filing a claim payment dispute. All information will be confidential.

The preferred method is to file a Claim Payment Dispute electronically via Availity Essentials.

Access the Claim Payment Dispute tool from Claim Status in Availity Essentials.

You may also submit a dispute via postal mail. The Payment Dispute Unit (PDU) will receive, distribute, and coordinate all claim payment disputes. To submit a claim payment dispute, please complete the Payment Dispute form located on our website and submit to:

Anthem Blue Cross and Blue Shield HP
Payment Dispute Unit
P.O. Box 61599
Virginia Beach, VA 23466-1599

File payment disputes within 45 calendar days of the paid date of the EOP by submitting a written request with an explanation of what is in dispute and why. Include supporting documentation such as an EOP, a copy of the claim, medical records, or contract page.

The PDU will research and determine the status of a payment dispute. A determination will be made on the available documentation submitted with the dispute and a review of our systems, policies, and contracts. Any payment dispute received with supporting clinical documentation will be retrospectively reviewed by a registered nurse. Established clinical criteria will be applied to the payment dispute. After retrospective review, the payment dispute may be approved or forwarded to the plan medical director for further review and resolution.

For untimely filing disputes, we will pay the claim(s) if you can demonstrate both of the following:

- Your noncompliance was a result of an unusual occurrence

You have a pattern or practice of timely submitting claims

A Level I determination letter will be sent to you within 30 calendar days from receipt of complete payment dispute information. The response will include the following information:

- Your name and Anthem ID number

Date of initial filing of concern

- Written description of the concern
- Decision
- Further dispute options

If you're dissatisfied with the Level I payment dispute resolution, you may file a Level II payment dispute. This should be a written dispute and submitted within 30 days of receipt of a Level I determination letter.

10 QUALITY MANAGEMENT

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 reflect the demographic and epidemiological needs of the population served. Members and providers have opportunities to make recommendations for areas of improvement. The Quality Management program goals and outcomes are available to providers and members upon request. To request a copy of our Quality Management program evaluation, please contact the Quality Management (QM) department at fax-qi@anthem.com.

The initial program development was based on a review of the needs of the population served. Systematic reevaluation of the needs of the plan's specific population occurs on an annual basis. This includes not only age/sex distribution but also 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. Studies are planned across the continuum of care and service, with ongoing proactive evaluation and refinement of the program.

There is a comprehensive committee structure in place with oversight from our governing body. The Medical Advisory Committee, Credentials Committee, and Quality Committee in place in addition to a Member and Consumer Advisory Committee, all are an integral component of the Quality Management Program committee structure.

Use of Performance Data

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

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, and contractual compliance.

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

Our quality program includes a 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.

Communicable Disease Reporting

The NYS and NYC Departments of Health require the reporting of all cases of communicable diseases. We will assist in this process by notifying PCPs when there has been a report of a potential communicable disease to us through our claim system. The diagnosis will be clarified, and for those members with a confirmed diagnosis of tuberculosis, sexually transmitted disease, hepatitis, or HIV, we will help the PCP with case management services if necessary.

Member Satisfaction Survey

To better serve our members, we conduct a member satisfaction survey, called the Consumer Assessment of Providers and Systems (CAHPS®) tool, each year. The CAHPS survey asks our members to rate their experiences with their doctors and/or specialists and health plans throughout the previous six months. More specifically, the survey asks if we provide good access to care, how quickly members were able to get appointments with providers and specialists, and if members feel they are getting the care they need. You play a critical role in the CAHPS survey — we count on you to help us improve healthcare quality. We report the results of the survey on a yearly basis, as well as some of the activities and initiatives that have been implemented to improve our performance and member satisfaction with our plan. To request a copy of the member satisfaction survey results, contact the QM department at **fax-qi@anthem.com**.

Quality Management Committee

The purpose of the Quality Management Committee is to maintain quality as a cornerstone of our culture and to be an instrument of change through demonstrable improvement in care and service.

The Quality Management Committee's responsibilities are to:
Establish strategic direction and monitor and support the implementation of the Quality Management program

- Establish processes and structure that ensure NCQA compliance
- Review planning, implementation, measurement, and outcomes of clinical/service quality improvement studies
- Coordinate communication of quality management activities throughout the health plans
- Review HEDIS data and action plans for improvement
- Review and approve the annual quality management program description

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

- Review and approve the annual work plans for each service delivery area
- Provide oversight and review 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 and provider satisfaction survey responses
- Monitor the plan's operational indicators through the plan's senior staff

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 the 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 to the monitoring of quality and the appropriateness of care. The MAC advises the health plan administration on 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 and the Utilization Review program and also reviews the Quality Management program. It also makes recommendations regarding health promotion activities.

The MAC's responsibilities are to:

Use an ongoing peer review system to monitor practice patterns to identify appropriateness of care and to improve 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

- Oversee member access to care

Review and provide feedback regarding new technologies

- Approve recommendations from subordinate committees

Quality Assurance Reporting Requirements

Quality Assurance Reporting Requirements (QARR) apply to our Child Health Plus, Essential Plan, and Medicaid Managed Care products.

QARR is a program overseen by the NYSDOH that monitors health plan quality in NYS. The program consists of a series of age-specific and/or health-specific measures designed to examine managed care plan performance in several key areas. QARR data is collected through encounter (claims) data from inpatient or outpatient visits, pharmacy data, laboratory claims, or from the member's medical record. The DOH uses QARR data to work

with plans and providers to enhance the health care outcomes of managed care members through performance feedback, quality improvement programs, technical assistance, and highlighting of best practices. All health plans in NYS are required to submit QARR data.

Examples of measures reported for QARR include:

- Adult access to care
- Timeliness and frequency of prenatal care and timeliness of postpartum care
- Comprehensive diabetes care
- Breast cancer screening
- Cervical cancer screening
- Appropriate treatment of asthma
- HIV/AIDS Comprehensive Care

Our internal claims system will collect pertinent QARR information as it is received. The balance of information will be extracted from member medical records, as necessary. Healthcare professionals from our Quality Management department will contact your office or facility to gain access to the medical records needed to collect the required information. All efforts will be made not to inconvenience you or your staff in the process. It is important to remember that the more information that can be extracted from claims data, the less likely a medical record review will be necessary.

Provider Profiling

The Program and Quality Management departments use provider-profiling methodology, rationale, and processes for classifying physician performance. The method applies to the following key measures: access and availability to care, member complaints, ER utilization, and PCP turnover rates.

The principal features of the methodology are:

Clearly defined goals and objectives for the profiling activity have been developed, including the communication of a profiling summary to providers and the provision of provider/office manager education, based on findings and corrective action plans with timetables and measurable benchmarks of success, as indicated.

Descriptions and rationale for each measure have been developed, and supporting clinical documentation included, when appropriate.

The measures selected for the profile meet the criteria for valid and reliable measurement and when analyzed as a whole, will be used as a tool to target opportunities for improvement. Additionally, a summary of these results will be shared with the physicians involved to promote continuous quality improvement activities.

- Quality profiles examine a broad range of practice measures and have some adjustments for risk, and similar cohorts are analyzed across practices to fairly compare each provider.

Profiles include data from multiple sources, including claims, QARR, medical record review data, utilization management and pharmacy data, member satisfaction surveys, enrollment and PCP assignment data, member complaints, and provider-supplied information, such as office hours, walk-in policies, etc.

Measure Selection Criteria

The measures selected for the physician quality profile met the following criteria:
The definition of the measure has been consistent over one year, meaning that the measurement methodology has not changed appreciably.
Data has been reported in the measurement area for a minimum of one year.

- The measure is readily understood, and its validity is accepted.
- The data for the measure are available and meet accepted standards for completeness.

The size of the population for selecting a measure is adequate. A panel size limit (completed only for panels of 100 or more) has been selected. In relation to QARR scores when reviewed by an individual provider, the population will often be too small to provide a statistically significant result but will nonetheless be reviewed as one measure of the provision of services.

Description and Definition of the Measures

QARR Indicator: A summary of applicable QARR measurement scores. The report details the population reviewed for each measure and the pass/fail experience of each member enrolled in the plan for at least one year. QARR scores for each group practice, individual PCP, and/or IPA are reported with the associated Anthem average as an indication of PCP performance in relation to one's peer group. This data is presented in its raw form, with no interpretation or comparative narration provided.

The following QARR measures are some of the components of this indicator:

- Adult access to primary care
- Cervical cancer screening
- Breast cancer screening
- Immunizations
- Well care

Physician Indices (Utilization Metrics): Includes the utilization experience of members as both a volume statistic and proportion of total panel membership. It includes provider visits as well as emergency room, inpatient, and nonparticipating provider/facility utilization.

Utilization:

- The proportion of members with a PCP visit during the year
- The proportion of members with an ER visit during the year

- The proportion of members with a visit to a nonparticipating provider/facility during the year
- The proportion of members admitted with conditions that are considered avoidable when managed effectively in an outpatient setting

Member Complaints: Complaint categories determined to be provider related are reviewed for volume, severity, and substantiation. Those related to access and availability, quality of care/treatment, physician office environment, reimbursement/billing disputes, or communication with PCP and/or office staff will be reviewed for the previous 12 months and reported as a raw score of complaints assigned to the PCP, as well as a ratio of complaints per 100 members for comparative purposes.

The following NYS reportable complaint categories will be reviewed for this purpose:

- Appointment availability
- Excessive wait time at provider's office
- Denial of clinical treatment
- Dissatisfaction with quality of care
- Dissatisfaction with provider services (nonmedical)
- Dissatisfaction with obtaining provider services after hours
- Difficulty obtaining referrals
- Communication/physical barriers
- Reimbursement/billing issues

Complaints will be identified as total complaints logged and total substantiated complaints.

Outcomes: All indices included in our provider-profiling summary will be presented in a standardized reporting format accessible to you upon request. A formal assessment of provider performance will be evaluated on a periodic basis using the previously stated criteria and an appropriate group of healthcare professionals using similar treatment modalities and serving a comparable patient population. The resulting report will be reviewed by the provider-profiling oversight committee, which will schedule onsite appointments with PCPs to present results and afford PCPs the opportunity to engage in dialogue regarding the report findings, discuss the unique nature of their practices and work cooperatively and collaboratively with the plan to assess opportunities to improve performance and/or identify practice areas which are working well. We reserve the right to use data about provider performance for business purposes.

Public Health Issues

We work with the NYC and NYS Departments of Health to identify, track and, when possible, address any public health issues that may arise in our member population. Some areas of focus are communicable disease reporting, lead testing and reporting, accessing, and

reporting to the City Immunization Registry (CIR), and child abuse and domestic violence identification and follow-up.

Domestic Violence

You're expected to screen for cases of domestic violence as part of routine assessments and should provide members with appropriate referrals when indicated. Questions regarding domestic violence should be referred to the Associate Vice President of Behavioral Health or the Domestic Violence Coordinator at **800-450-8753**. In addition, you may contact the NYS Domestic Violence Hotline at **800-9426-906**.

HIV Testing

New York requires that HIV testing must be offered to all individuals between the ages of 13 and 64 receiving hospital or primary care services and diagnosis and treatment services; services include pre- and post-counseling and coordination for medical care for individuals confirmed as positive. Facilities can create their own consent form as long as the language is consistent with standardized, DOH-created model forms. Consent may be part of a general consent to medical care, though specific opt-out language for HIV testing must be included. Consent for rapid HIV testing can be oral (except in correctional facilities) and noted in the medical record. Additional information regarding HIV testing laws can be found at health.ny.gov/diseases/aids/testing/law/faqs.htm.

HIV Services

The prenatal provider will:

- Routinely provide the pregnant woman with HIV counseling and education.
- Routinely offer the pregnant woman confidential HIV testing.
- Routinely recommend the pregnant woman to HIV counseling and testing as early as possible in the pregnancy, including a repeat third-trimester test (preferably at 34-36 weeks).
- Provide the HIV-positive woman and her newborn infant with the following services or make the necessary referrals for these services:
  - Management of HIV status
  - Psychosocial support
  - Case management to assist in coordination of necessary medical, social, and drug treatment services

Clinical Practice Guidelines

Using nationally recognized standards of care, Anthem works with providers to develop clinical policies and guidelines for the care of our membership.

To access the Clinical Practice Guidelines online, navigate to our website at providers.anthem.com/ny. You can contact Provider Services at **800-450-8753** to receive a printed copy.

Anthem Clinical and Network staff is available to review these practices and guidelines. These reviews can occur in a group setting, via WebEx, or in person.

Periodically, the plan's quality team will request charts to ensure all providers (PCPs, behavioral health providers, and all specialists) are following the guidelines and are incorporating evidence-based practices. The results of these audits and next steps will then be reviewed with the Medical Advisory Committee.

11 CREDENTIALING

ANTHEM'S DISCRETION

The credentialing summary, criteria, standards, and requirements set forth herein are not intended to limit Anthem's discretion in any way to amend, change or suspend any aspect of Anthem's credentialing program ("Credentialing Program") nor is it intended to create rights on the part of practitioners or HDOs who seek to provide healthcare services to members. Anthem further retains the right to approve, suspend, or terminate individual physicians and health care professionals, and sites in those instances where it has delegated credentialing decision making.

Credentialing Scope

Credentialing requirements apply to the following:

1. Practitioners who are licensed, certified or registered by the state to practice independently (without direction or supervision);
2. Practitioners who have an independent relationship with Anthem
   An independent relationship exists when Anthem directs its members to see a specific practitioner or group of practitioners, including all practitioners whom a member can select as primary care practitioners; and
3. Practitioners who provide care to members under Anthem's medical benefits.

The criteria listed above apply to practitioners in the following settings:

- Individual or group practices
- Locum tenens:
  - Provisional Credentialing is required if these practitioners work less than 60 calendar days.
  - Full Credentialing is required if these practitioners work 60 calendar days or more.
  - Covering practitioners (e.g., locum tenens) who do not have an independent relationship with the Company are not included in the Credentialing scope.
- Facilities
- Rental networks
  - That are part of Anthem's primary Network and include Anthem members who reside in the rental network area.
  - That are specifically for out-of-area care and members may see only those practitioners or are given an incentive to see rental network practitioners; and
- Telemedicine
- PPO network:
  - If an organization contracts with a PPO network to provide health services to members who need care outside its service area, and if it encourages members

to obtain care from that network when they are outside the network, NCQA considers this to be an

- independent relationship if:
  - Information about the network is included in member materials or on an ID card that directs members to the network (e.g., network name, phone number, logo), ***or***
  - There are incentives for members to see the PPO's practitioners.
  - In this type of contractual arrangement, the organization must credential the
  - practitioners or delegate credentialing to the PPO network.

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

- Medical Doctors (MD)
- Doctors of Osteopathic Medicine (DO)
- Doctors of Podiatry
- Chiropractors
- Optometrists providing Health Services covered under the Health Benefit Plan
- Doctors of dentistry providing Health Services covered under the Health Benefit Plan including oral and maxillofacial surgeons
- Psychologists who have doctoral or master's level training
- Clinical social workers who have master's level training
- Psychiatric or behavioral health nurse practitioners who have master's level training
- Other behavioral health care specialists who provide treatment services under the Health Benefit Plan
- Telemedicine practitioners who provide treatment services under the Health Benefit Plan
- Medical therapists (e.g., physical therapists, speech therapists, and occupational therapists)
- Genetic counselors
- Audiologists
- Acupuncturists (non-MD/DO)
- Nurse practitioners
- Certified nurse midwives
- Physician assistants (as required locally)
- Registered Dietitians

The following behavioral health practitioners are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing

board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Certified Behavioral Analysts
- Certified Addiction Counselors
- Substance Use Disorder Practitioners

Anthem credentials the following Health Delivery Organizations (HDOs):

- Hospitals
- Home Health agencies
- Skilled Nursing facilities (Nursing Homes)
- Ambulatory Surgical Centers
- Behavioral Health facilities providing mental health and/or substance use disorder treatment in inpatient, residential or ambulatory settings, including:
    - Adult Family Care/Foster Care Homes
    - Ambulatory Detox
    - Community Mental Health Centers (CMHC)
    - Crisis Stabilization Units
    - Intensive Family Intervention Services
    - Intensive Outpatient – Mental Health and/or substance use disorder
    - Methadone Maintenance Clinics
    - Outpatient Mental Health Clinics
    - Outpatient Substance Use Disorder Clinics
    - Partial Hospitalization – Mental Health and/or substance use disorder
    - Residential Treatment Centers (RTC) – Psychiatric and/or substance use disorder
- Birthing Centers
- Home Infusion Therapy when not associated with another currently credentialed HDO
- Durable Medical Equipment providers

The following HDOs are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process as directed by CMS including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)
  End Stage Renal Disease (ESRD) service providers (dialysis facilities) (CMS Certification or National Dialysis Accreditation Commission
- Portable x-ray Suppliers (CMS Certification)

- Home Infusion Therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)
- Federally Qualified Health Centers (FQHC) (CMS Certification)
- Rural Health Clinics (CMS Certification)
- Orthotics and Prosthetics Suppliers (American Board for Certification in Orthotics and Prosthetics_(ABCOP) or Board of Certification/Accreditation (BOC) or The National Examining Board of Ocularists (NEBO))

CREDENTIALS COMMITTEE

The decision to accept, retain, deny or terminate a practitioner's or HDO's participation in one or more of Anthem's networks or plan programs is conducted by a peer review body, known as Anthem's Credentials Committee (the "CC").

The CC will meet at least once every 45 calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the Vice President of Medical and Credentialing Policy, will designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. In states or regions where Medicare Advantage (MA) is represented, a second vice-chair representing MA may be designated. In states or regions where an Anthem affiliated provider organization is represented, a second vice-chair representing that organization may be designated. The chair must be a state or regional lead medical director, or an Anthem medical director designee and the vice-chair must be a lead medical officer or an Anthem medical director designee, for that line of business not represented by the chair. In states or regions where only one line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five, but no more than 10 external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types of credentialed health providers (e.g., nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair's discretion. At least two of the physician committee members must be credentialed for each line of business (e.g., Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise

be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant's participation or terminate a practitioner from participation in one or more Networks or Plan programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are network practitioners.

During the credentialing process, all information that is obtained is confidential and not subject to review by third parties except to the extent permitted by law. Access to information will be restricted to those individuals who are deemed necessary to attain the objectives of the Credentialing Program. Specifically, information supplied by the practitioner or HDO in the application, as well as other non-publicly available information will be treated as confidential. Confidential written records regarding deficiencies found, the actions taken, and the recommended follow-up will be kept in a secure fashion. Security mechanisms include secured office facilities and locked filing cabinets, a protected computer infrastructure with password controls and systematic monitoring, and staff ethics and compliance training programs. The procedures and minutes of the CC will be open to review by state and federal regulatory agencies and accrediting bodies to the extent permitted by law.

Practitioners and HDOs are notified of their right to review information submitted to support their credentialing applications. If credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, Anthem's credentialing staff ("Credentialing Department") will contact the practitioner or HDO within 30 calendar days of the identification of the issue. This communication will notify the practitioner or HDO of their right to correct erroneous information or provide additional details regarding the issue and will include the process for submission of this additional information. Depending on the nature of the issue, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue, including copies of the correspondence or a detailed record of phone calls, will be documented in the practitioner's or HDO's credentials file. The practitioner or HDO will be given no less than 14 calendar days in which to provide additional information. Upon request, the practitioner or HDO will be provided with the status of their credentialing or re-credentialing application.

Anthem may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

NONDISCRIMINATION POLICY

Anthem will not discriminate against any applicant for participation in its programs or provider network(s) based on race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically

mentioned herein. Anthem is required to include fields for the collection of practitioner race, ethnicity, and language on the application. However, Anthem does not use such reports to discriminate against a practitioner, and the application includes a statement indicating the provision of such information is optional. Additionally, Anthem will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Determinations as to which practitioners and providers require additional individual review by the Credentials Committee are made according to predetermined criteria related to professional conduct and competence. Credentials Committee decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Anthem will review denials and terms for consistency and lack of discrimination annually to identify discriminatory practices in the selection of practitioners. These reviews are documented in a report summary format by reason for the denial or term for initial denials, recredentialing, terminations, and off-cycle terminations. The reasons for denial or term include: not board certified, license/board action, malpractice, education/training, hospital privileges, criminal conviction, DEA, hospital action, insurance, work history gap, and federal sanctions. In addition, annually audits of practitioner complaints about credentialing shall be reviewed for evidence of alleged discrimination. Should discriminatory practices be identified through annual review or through other means, Anthem will take appropriate action(s) to track and eliminate those practices.

INITIAL CREDENTIALING

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

Anthem will verify those elements related to an applicants' legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the 120-calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards. The application attestation including work history verification must be dated and verified within 180 calendar days prior to the Credentials Committee decision.

During the credentialing process, Anthem will review, among other things, verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

A. Practitioners

Verification Element
License to practice in the state(s) in which the practitioner will be treating members.
Hospital admitting privileges at a TJC, DNV NIAHO, CIHQ or ACHC accredited hospital, or a Network hospital previously approved by the committee.
DEA/CDS and state-controlled substance registrations • The DEA/CDS registration must be valid in the state(s) in which practitioner will be treating ,embers. Practitioners who see members in more than one state must have a DEA/CDS registration for each state.
Malpractice insurance
Malpractice claims history
Board certification or highest level of medical training or education
Work history
State or Federal license sanctions, exclusions or limitations
Medicare, Medicaid or FEHBP sanctions and exclusions
National Practitioner Data Bank report
State Medicaid Exclusion Listing, if applicable

B. HDOs

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

RE-CREDENTIALING

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

All applicable practitioners and HDOs in the Network within the scope of the Credentialing Program are required to be re-credentialed every three years unless otherwise required by applicable state contract or state regulations.

HEALTH DELIVERY ORGANIZATIONS

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

ONGOING SANCTION MONITORING

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

- Office of the Inspector General ("OIG")
- Federal and State Medicare/Medicaid Reports
- Office of Personnel Management ("OPM")
- State licensing Boards/Agencies
- Member/Customer services departments
- Clinical Quality Management Department (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
- Other internal Anthem departments
- Any other information received from sources deemed reliable by Anthem.

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

APPEALS PROCESS

Anthem has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one or more of Anthem's Networks or Plan Programs. Information reviewed during this activity may indicate that the professional conduct and

competence standards are no longer being met, and Anthem may wish to terminate practitioners or HDOs. Anthem also seeks to treat network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating/denying participation in Anthem's Networks for professional conduct and competence reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB).

Additionally, Anthem will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is Anthem's intent to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one or more of Anthem's Networks or Plan Programs and those denials of request for initial participation which are reported to the NPDB that were based on professional conduct and competence considerations.

Immediate terminations may be imposed due to the practitioner's or HDO's license suspension, probation or revocation, if a practitioner or HDO has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, has a criminal conviction, or Anthem's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to members. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for informal review/reconsideration or formal appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for informal review/reconsideration or formal appeal.

REPORTING REQUIREMENTS

When Anthem takes a professional review action with respect to a practitioner's or HDO's participation in one or more of its Networks or Plan programs, Anthem may have an obligation to report such to the NPDB, state licensing board and legally designated agencies. If the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

ANTHEM CREDENTIALING PROGRAM STANDARDS

Eligibility Criteria

A. Health care practitioners:

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

A. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP;

B. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he or she provides services to members;
C. Possess a current, valid, and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating members. Practitioners who see members in more than one state must have a DEA/CDS registration for each state; and
D. Meet the education, training and certification criteria as required by Anthem.

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

A. For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine ("ABPM"), or American Board of Oral and Maxillofacial Surgery (ABOMS) in the clinical discipline for which they are applying.
B. If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
C. If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.
D. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.

    1. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
        i. Previous board certification (as defined by one) of the following: ABMS, AOA, RCPSC, CFPC, ABFAS, ABPM, or ABOMS) in the clinical specialty or subspecialty for which they are applying which has now expired and a minimum of 10 consecutive years of clinical practice;
        ii. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty; or
        iii. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty and a faculty appointment of assistant professor or higher at an academic medical center and teaching facility in Anthem's network and the

applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.

2. Practitioners meeting one of these three alternative criteria (i., ii., iii.) will be viewed as meeting all Anthem education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Anthem review and approval. Reports submitted by delegates to Anthem must contain sufficient documentation to support the above alternatives, as determined by Anthem.

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

F. For Genetic Counselors, the applicant must be licensed by the state to practice independently. If the state where the applicant practices does not license Genetic Counselors, the applicant must be certified by the American Board of Genetic Counseling or the American Board of Genetics and Genomics.

G. For Registered Dieticians (RD), the applicant must have completed a bachelor's degree at a US regionally accredited university or college and course work accredited or approved by the Accreditation Council for Education in Nutrition and Dietetics (ACEND) of the Academy of Nutrition and Dietetics. Completion of an ACEND accredited supervised practice program at a healthcare facility, community agency, or a foodservices corporation or combined with undergraduate or graduate studies. Typically, a practice program will run six (6) to twelve (12) months in length. Must have passed a national examination administered by the Commission on Dietetic Registration (CDR).

<u>Criteria for Selecting Practitioners</u>

New Applicants (Credentialing):

a. Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions.
b. Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote.
c. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies.
d. No evidence of potential material omission(s) on application.
e. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to members.
f. No current license action.
g. No history of licensing board action in any state.
h. No current federal sanction or exclusion and no history of federal sanctions or exclusions (per System for Award Management (SAM), OIG and OPM report nor on NPDB report).
i. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating members. Practitioners who treat members in more than one state must have a valid DEA/CDS registration for each applicable state.
j. Initial applicants who voluntarily have no DEA/CDS registration, the exception listed below may apply or if the applicant can provide evidence that he or she has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:
    a. It can be verified that this application is pending.
    b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber;
    c. The applicant agrees to notify Anthem upon receipt of the required DEA/CDS registration.
    d. Anthem will verify the appropriate DEA/CDS registration via standard sources.
        i. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90-calendar day timeframe will result in termination from the Network.

<u>Initial</u> applicants who possess a DEA certificate in a state other than the state in which they will be seeing Anthem's members will be notified of the need to obtain the additional DEA, unless the practitioner is delivering services in a telemedicine environment only and does not require a DEA or CDS registration in the additional location(s) where such telemedicine services may be rendered under federal or state

law. If the applicant has applied for an additional DEA registration the credentialing process may proceed if all the following criteria are met:

a. It can be verified that the applicant's application is pending; and

- The applicant has arranged for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
- The applicant agrees to notify Anthem upon receipt of the required DEA registration; and
- Anthem will verify the appropriate DEA/CDS registration via standard sources; and
- The applicant agrees that failure to provide the appropriate DEA registration within a 90-day timeframe will result in termination from the network.

Practitioners who voluntarily choose to not have a DEA/CDS registration if that practitioner certifies the following:

a. controlled substances are not prescribed within his/her scope of practice; or in their professional judgement, the patients receiving their care do not require controlled substances and
b. he or she must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances should it be clinically appropriate. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber; and
c. DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than those aforementioned.

k. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions; or for Practitioners in specialties defined as requiring hospital privileges who practice solely in the outpatient setting, there exists a defined referral arrangement with a participating Practitioner of similar specialty at a participating hospital who provides inpatient care to members requiring hospitalization.
l. No history of or current use of illegal drugs or history of or current substance use disorder.
m. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
n. No gap in work history greater than six months in the past five years; however, gaps up to 12 months related to parental leave or immigration will be acceptable and viewed as Level I. All gaps in work history exceeding six months will require additional information and review by the Credentialing Department. A verbal explanation will be accepted for gaps of six to 12 months. Gaps in excess of 12 months will require written explanations. All work history gaps exceeding six months may be presented to the geographic CC if the gap raises concerns of future substandard Professional Conduct and Competence.
o. No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony

or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence.

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

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

Participation Criteria and Exceptions for Non-Physician Credentialing.

The following participation criteria and exceptions are for non-MD practitioners. It is not additional or more stringent requirements, but instead the criteria and exceptions that apply for these specific provider types to permit a review of education and training.

1. Licensed Clinical Social Workers (LCSW) or other master level social work license type based on state licensing regulations:
    a. Master or doctoral degree in social work.
    b. If master's level degree does not meet criteria and practitioner obtained PhD degree as a clinical psychologist, but is not licensed as such, the practitioner

can be reviewed. In addition, a Doctor of Social Work will be viewed as acceptable.

c. Licensure to practice independently.

2. Licensed professional counselor ("LPC"), marriage and family therapist ("MFT"), licensed mental health counselor (LMHC) or other master level license type based on state licensing regulations:
    a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
    b. Master's or doctoral degrees in divinity, master's in biblical counseling, or other primarily theological field of study do not meet criteria as a related field of study.
    c. Practitioners with PhD training as a clinical psychologist can be reviewed.
    d. Practitioners with a doctoral degree in one of the fields of study will be viewed as acceptable.
    e. Licensure to practice independently or in states without licensure or certification:
        i. Marriage & Family Therapists with a master's degree or higher:
            - Certified as a full clinical member of the American Association for Marriage and Family Therapy (AAMFT), OR proof of eligibility for full clinical membership in AAMFT (documentation from AAMFT required).
        ii. Mental Health Counselors with a master's degree or higher:
            - Provider applicant must be a Certified Clinical Mental Health Counselor (CCMHC) as determined by the Clinical Academy of the National Board of Certified Counselors (NBCC) (proof of NBCC certification required) or meet all requirements to become a CCMHC (documentation of eligibility from NBCC required).

3. Pastoral Counselors:
    a. Master's or doctoral degree in a mental health discipline.
    b. Licensed as another recognized behavioral health provider type (e.g., MD/DO, PsyD, SW, RNCS, ARNP, and MFT, OR LPC) at the highest level of independent practice in the state where the practice is to occur OR must be licensed or certified as a pastoral counselor in the state where the practice is to occur.
    - A fellow or diplomat member of the Association for Clinical Pastoral Education (ACPE) OR meet all requirements to become a fellow or diplomat member of the ACPE [documentation of eligibility of ACPE required].

4. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
    a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing.

b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
c. Certification by the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA) in psychiatric nursing, or the Pediatric Nursing Certification Board. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner; and
d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating members.

4. Clinical Psychologists:
   - Valid state clinical psychologist license.
   - Doctoral degree in clinical or counseling, psychology or other applicable field of study.
   - Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.

5. Clinical Neuropsychologist:
   a. Must meet all the criteria for a clinical psychologist listed in Section 4 above and be Board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN);
   b. A practitioner credentialed by the National Register of Health Service Providers (National Register) in psychology with an area of expertise in neuropsychology may be considered; and
   c. Clinical neuropsychologists who are not board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
      i. Transcript of applicable pre-doctoral training;
      ii. Documentation of applicable formal one-year post-doctoral training (participation in CEU training alone would not be considered adequate);
      iii. Letters from supervisors in clinical neuropsychology (including number of hours per week); or
      iv. Minimum of five years' experience practicing neuropsychology at least ten hours per week.

6. Licensed Psychoanalysts:
    a. Applies only to practitioners in states that license psychoanalysts.
    b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Anthem Credentialing Policy (e.g., psychiatrist, clinical psychologist, licensed clinical social worker).
    c. Practitioner must possess a valid psychoanalysis state license.
        1. Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
        2. Meet examination requirements for licensure as determined by the licensing state.

7. Process, requirements and Verification – Nurse Practitioners:
    a. The nurse practitioner (NP) applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
    b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the licensing agency does not verify the highest level of education, the education will be primary source verified in accordance with policy.
    c. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
    d. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Anthem procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.
    e. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
        i. Certification program of the American Nurse Credentialing Center, a subsidiary of the American Nursing Association;
        ii. American Academy of Nurse Practitioners – Certification Program;
        iii. National Certification Corporation;

iv. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner);
v. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY; or
vi. American Association of Critical Care Nurses Acute Care Nurse Practitioner Certification (ACNPC); ACNPC-AG – Adult Gerontology Acute Care. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.

f. If the NP has hospital privileges, he or she must have hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee. Information regarding the history of any actions taken against any hospital privileges held by the nurse practitioner will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.
g. The NP applicant will undergo the standard credentialing processes outlined in Anthem's Credentialing Policies. NPs are subject to all the requirements outlined in the Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for failure to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.

8. Process, Requirements and Verifications – Certified Nurse Midwives:
    a. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training and board certification.
    b. The required educational/training will be at a minimum that required for licensure as a registered nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur via primary source verification of the license, provided that the state licensing agency performs verification of the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
    c. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
    d. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority

information will be requested and primary source verified via normal Anthem procedures. If there are current adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.

e. All CNM applicants will be certified by either:
    i. The National Certification Corporation for Ob/Gyn and neonatal nursing; or
    ii. The American Midwifery Certification Board, previously known as the American College of Nurse Midwifes.

   This certification must be active. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic CC.

h. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding the history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. In the event the CNM provides only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.

i. The CNM applicant will undergo the standard credentialing process outlined in Anthem's Credentialing Policies. CNMs are subject to all the requirements of the Credentialing Policies including (but not limited to): the requirement for CC review for Level II applicants, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the Network.

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

a. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.

b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.

c. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.

d. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Anthem procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
e. All PA applicants will be certified by the National Commission on Certification of Physician's Assistants. This certification must be active. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy #8, as adopted or amended by each Anthem Health Plan and submitted for individual review by the CC.
f. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee. Information regarding the history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
g. The PA applicant will undergo the standard credentialing process outlined in Anthem's Credentialing Policies. PAs are subject to all the requirements described in these Credentialing Policies including (but not limited to): committee review of Level II files failing to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.

Currently Participating Applicants (Re-credentialing)

1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
2. Re-credentialing application signed date 180 calendar days of the date of submission to the CC for a vote;
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP. If, once a practitioner participates in Anthem's Plan programs or provider Networks, federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the practitioner will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Anthem's other credentialed provider Networks.
4. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to members;
5. No new history of licensing board reprimand since prior credentialing review;
6. *No current federal sanction or exclusion and no new (since prior credentialing review) history of federal sanctions or exclusions (per SAM, OIG and OPM Reports or on NPDB report);
7. Current DEA/CDS registration and/or state-controlled substance certification without new (since prior credentialing review) history of or current restrictions;

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

*It is expected that these findings will be discovered for currently credentialed network practitioners and HDOs through ongoing sanction monitoring. Network practitioners

and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: the CC will individually review any credentialed Network practitioners and HDOs that do not meet one or more of the criteria for re-credentialing.

B. HDO Eligibility Criteria

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

A. General Criteria for HDOs:

- Valid, current and unrestricted license to operate in the state(s) in which it will provide services to members. The license must be in good standing with no sanctions.
    1. Valid and current Medicare certification.
- Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the FEHBP. Note: If, once an HDO participates in Anthem's Plan programs or provider Networks, exclusion from Medicare, Medicaid or FEHBP occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Anthem's other credentialed provider Networks.
    2. Liability insurance acceptable to Anthem.
- If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if Anthem's quality and certification criteria standards have been met.

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B. Additional Participation Criteria for HDO by Provider Type:

HDO TYPE AND ANTHEM APPROVED ACCREDITING AGENT(S)

Facility Type (Medical Care)	Acceptable Accrediting Agencies

Acute Care Hospital	CIQH, TCT, DNV NIAHO, ACHC, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, ACHC, TJC
Birthing Center	AAAHC, CABC, TJC
Home Health Care Agencies (HHA)	ACHC, CHAP, DNV NIAHO, TJC, TCT
Home Infusion Therapy (HIT)	ACHC, CHAP, TCT, TJC
Skilled Nursing Facilities/Nursing Homes	CARF, TJC
Durable Medical Equipment Suppliers	TJC, CHAP, TCT, ACHC, BOC, HQAA

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	DNV NIAHO, ACHC, TJC, TCT
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, TJC, ACHC
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or substance use disorder	ACHC, CARF, COA, DNV NIAHO, TJC
Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinics	CARF, CHAP, COA, ACHC, TJC
Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or substance use disorder	CARF, DNV NIAHO, TJC
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or substance use disorder	CARF, COA, DNV NIAHO, ACHC, TJC

Facility Type (Behavioral Health Care -Rehabilitation)	Acceptable Accrediting Agencies
Acute Inpatient Hospital – Detoxification Only facilities	TCT, DNV NIAHO, ACHC, TJC
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC
Outpatient Substance Use Disorder Clinics	CARF, TJC, COA,

Note:

When credentialing Office for People With Developmental Disability (OPWDD) and Office of Mental Health (OMH)-licensed, OMH-operated, and Office of Addiction Services And Supports (OASAS)-certified providers, the Company shall accept OPWDD, OMH, and OASAS licenses, operation and certifications in place of, and not in addition to, any Company credentialing process for individual employees, subcontractors or agents of such providers.

The Health Plan is required to check the Social Security Death Master (SSDM) and National Plan and Provider Enumeration System (NPPES) for new providers, re-enrolled providers, and all current participating providers who were not checked upon enrollment into the contractor's Medicaid Program

12 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 an 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 the 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 the following resources.

MyDiversePatients.com: The My Diverse Patients website offers resources, information, and techniques, to help provide the individualized care every patient deserves regardless of their

diverse backgrounds. The site also includes learning experiences on topics related to cultural competency and disparities that offer free Continuing Medical Education (CME) credit. Current CME offerings include:

- **Caring for Children with ADHD:** Promotes understanding of and adherence to diagnosis and treatment guidelines; use of AAP's Resource Toolkit for Clinicians; awareness of and strategies for addressing disparities.
- **My Inclusive Practice — Improving Care for LGBTQIA+ Patients:** Helps providers understand the fears and anxieties LGBTQIA+ patients often feel about seeking medical care, learn key health concerns of LGBTQIA+ patients, & develop strategies for providing effective health care to LGBTQIA+ patients.

Improving the Patient Experience: Helps providers identify opportunities and strategies to improve patient experience during a healthcare encounter.
Medication Adherence: Helps providers identify contributing factors to medication adherence disparities for diverse populations & learn techniques to improve patient-centered communication to support the needs of diverse patients.

- **Moving Toward Equity in Asthma Care:** Helps providers understand issues often faced by diverse patients with asthma & develop strategies for communicating to enhance patient understanding.

Reducing 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 health care 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.

13 AMERICANS WITH DISABILITIES ACT REQUIREMENTS

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

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

14 FRAUD, WASTE, AND ABUSE

General Obligation to Prevent, Detect and Deter Fraud, Waste and Abuse

As a recipient of funds from state and federally sponsored healthcare programs, we each have a duty to help prevent, detect, and deter fraud, waste, and abuse. Our commitment to detecting, mitigating, and preventing fraud, waste, and abuse is outlined in our Corporate Compliance Program. As part of the requirements of the federal Deficit Reduction Act, each Anthem provider is required to adopt Anthem policies on detecting, preventing, and mitigating fraud, waste, and abuse in all the federally and state-funded healthcare programs in which Anthem participates.

To meet the requirements under the Deficit Reduction Act, you must adopt the Anthem fraud, waste and abuse policies and distribute them to any staff members or contractors who work with Anthem. If you have questions or would like more details concerning our fraud, waste and abuse detection, prevention, and mitigation program, please contact the Anthem Chief Compliance Officer.

Electronic copies of our policy and the Anthem Code of Business Conduct and Ethics are available at providers.anthem.com/ny.

What is Fraud, Waste, and Abuse?

Healthcare fraud costs taxpayers increasingly more money every year. There are state and federal laws designed to crack down on these crimes and impose strict penalties. Fraud, waste, and abuse in the healthcare industry may be perpetuated by every party involved in the healthcare process. There are several stages to inhibit fraudulent acts, including detection, prevention, investigation, and reporting. In this section, we educate providers on how to help prevent member and provider fraud by identifying the different types, so you can be the first line of defense. We start by learning about these issues and being aware of them.

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.

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 that 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 (for example, the doctor(s) name(s), the 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 an out-of-service Plan area and not notifying us

- Using someone else's ID card

When reporting concerns involving a MEMBER include:

- The Member's name
- The Member's date of birth, Member ID, or case number if you have it

The city where the Member resides
Specific details describing the fraud, waste or abuse

What Can You Do to Help Prevent Fraud, Waste, and Abuse?

- Carefully review each member's Anthem member ID card to ensure the cardholder is the person named on the card; this is the first line of defense against fraud

  (Note: Anthem may not accept responsibility for the costs incurred by providers rendering services to a patient who is not a member, even if that patient presents an Anthem member ID card.)
- Educate members about the types of fraud and the penalties levied
- Spend time with patients and review their records for prescription administration

Encourage members to protect their cards as they would a credit card or cash, to always carry their Anthem member ID card, and to report any lost or stolen cards to Anthem as soon as possible

Anthem believes awareness and action are vital to keeping the state and federal programs safe and effective. Understanding the various opportunities for fraud, waste, or abuse and working with members to protect their Anthem identification cards can help prevent fraud, waste, and abuse.

Reporting Fraud, Waste, and Abuse

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

You can report your concerns by:

- Visiting our **www.fighthealthcarefraud.com** education site; at the top of the page select "Report it" and complete the "**Report Waste, Fraud and Abuse**" form
- Participating providers can call Provider Experience
- Any individual can call Customer Service **800-450-8753** or the SIU fraud referral hotline: **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.

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 investigative findings are reported to all appropriate state, regulatory, and/or law enforcement agencies. In addition to reporting, we may take corrective action with Provider fraud, waste, or abuse, which may include, but is not limited to:

- *Written warning and/or education*: We send secure/trackable communications to the Provider documenting the issues and the need for improvement. Correspondence may include education or requests for recoveries or may advise of further action.
- *Medical record review*: We review medical records in context of previously submitted claims and/or to substantiate allegations.

- *Prepayment Review*: A certified professional coder evaluates claims prior to payment of designated claims. This editing 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 on future claims and/or further legal action.

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

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

Instructions for sending paper medical records and/or claims when working with the SIU is found in correspondence from the SIU. If you have questions, contact your investigator. Delays for claim and/or medical record review, and ultimately, resolution of an investigation may be delayed if SIU-supplied instructions are not followed. An opportunity to submit claims and medical records electronically is an option if you register for an Availity Essentials account. Contact Availity Essentials 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 the 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 that 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 of 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.

Offsets

Anthem shall be entitled to offset claims and recoup an amount equal to any overpayments ("Overpayment Amount") or improper payments made by the health plan to provider or facility against any payments due and payable by the health plan to provider or facility with respect to any Health Benefit Plan under any contract with our company regardless of the cause. Provider or facility shall voluntarily refund the overpayment amount regardless of the cause, including, but not limited to, payments for claims where the claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether the billing error was fraudulent, abusive or wasteful. Upon determination by the Health Plan that an overpayment amount is due from provider or facility, provider or facility must refund the overpayment amount within the timeframe specified in letter notifying the provider or

facility of the overpayment amount. If the overpayment amount is not received within the timeframe specified in the notice letter, the Health Plan shall be entitled to offset the unpaid portion of the overpayment amount against other claims payments due and payable by Anthem to provider or facility under any Health Benefit Plan in accordance with Regulatory requirements. Should provider or facility disagree with any determination, provider or facility shall have the right to appeal such determination under Anthem procedures set forth in this Provider Manual, on condition that that such appeal shall not suspend [health plan brand] right to recoup the overpayment amount during the appeal process unless required by Regulatory requirements. Anthem reserves the right to employ a third-party collection agency in the event of non-payment.

15 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT & PROTECTED HEALTH INFORMATION

The Health Insurance Portability and Accountability Act (HIPAA, also known as the Kennedy-Kassebaum bill) 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.

Anthem strives 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. Effective April 14, 2003, contracted providers shall have the following procedures implemented to demonstrate compliance with the HIPAA privacy regulations.

Anthem recognizes our responsibility under the HIPAA privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose. Conversely, network providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting Anthem. 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 to 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 Anthem, verify that the 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 Anthem (e.g., 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, post office box, or department at Anthem.

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

When contacting Anthem, please be prepared to verify the provider's name, address, and Tax Identification Number (TIN), National Provider Identifier (NPI), or Anthem provider number.

16 MEMBER MANAGEMENT SUPPORT

Welcome Call

As part of our member management strategy, we offer a welcome call to new members. During the welcome call, new members who have been identified through their health risk assessment as possibly needing additional services are educated regarding the health plan and available services. Additionally, Member Services representatives offer to assist the member with any current needs, such as scheduling an initial checkup, assisting new members whose healthcare provider is not a member of the network, and requesting to continue an ongoing course of treatment with the member's current provider. Circumstances would include if the member has a life-threatening disease, condition, or a degenerative and disabling disease or condition (the transitional period is up to 60 days).

Appointment Scheduling

Anthem, through our participating providers, ensures members have access to primary care services for routine, urgent, and emergency services and to specialty care services for chronic and complex care. Providers will respond to an Anthem member's needs and requests in a timely manner. The PCP should make every effort to schedule Anthem members for appointments using the guidelines outlined in the PCP Access and Availability section of this manual.

24/7 NurseLine

The Anthem 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 Anthem 4/7 NurseLine telephone number is **800-300-8181** 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:

- Constant availability — 24 hours a day, 7 days a week
- Access to information based upon nationally recognized and accepted guidelines
- Free translation services for 200 different languages and for members with difficulty hearing

Education for members about appropriate alternatives for handling nonemergent medical conditions

- Provider updates — A nurse faxes the member's assessment report to the provider's office within 24 hours of the call

Emergency Behavioral Health Calls

When a member in crisis contacts Anthem using the toll-free number, the member may bypass the prompts and be connected directly to a call center agent. The member in crisis is then connected to the first available behavioral health agent. If the member does not choose this option, then the member has the option to select the type of assistance needed – either physical or behavioral health. If the member chooses the physical health option and the Member Services agent determines that the member may be in crisis, the call is then transferred to a Behavioral Health agent.

The Behavioral Health agent will determine if the call is a true crisis situation. In the event it is a crisis, the call is transferred to a licensed clinician to handle the call. The member is kept on the phone until a clinician comes on the line. The clinician engages the member and based on the discussion, the clinician may determine that the member needs to be screened at the emergency room. If the clinician makes the determination that the member needs to be screened, the clinician will obtain the assistance of a backup clinician or agent to assist with the call to 911 while the clinician keeps the member on the phone until emergency services arrive to assist the member.

The clinician that services the call will document the call and contact the health plan case manager if the member is in Case Management, or the manager of Case Management for further assistance and follow-up. This allows the member to receive additional follow-up and services as needed to prevent future crisis situations.

Crisis calls are handled the same way during normal business hours, after hours, and weekends. All crisis calls are answered by a live person.

Interpreter Services

Interpreter services are available for our members if needed. Contact your Provider Relations representative for details.

Health Promotion

Anthem strives 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 health education classes are coordinated with community organizations and network providers who are contracted with Anthem.

Anthem manages projects that offer our members education and information regarding their health. Ongoing projects include:

- 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)
- Development of health education curricula and procurement of other health education tools (e.g., breast self-exam cards)
- Relationship development with community-based organizations to enhance opportunities for members

Case Management
Case management is designed to proactively respond to a member's needs when conditions or diagnoses require care and treatment for long periods of time. When a member is identified (usually through precertification, admission review, and/or provider or member request), the case manager (an Anthem nurse or social worker) helps to identify medically appropriate alternative methods or settings in which care may be delivered.

A provider, on behalf of the member, may request participation in the program. The case manager will work with the member, provider, and/or hospital to identify the necessary:

- Intensity level of case management services needed
- Appropriate alternate settings where care may be delivered

Health care services required
Equipment and/or supplies required

- Community-based services available
- Communication required (i.e., between member and PCP)

The Anthem case manager will assist the member, Utilization Review team and PCP and/or hospital in developing the discharge plan of care, ensuring the member's medical needs are met and linking the member with community resources and Anthem programs for outpatient case and/or disease management. Anthem case managers are available from 9 a.m. to 5 p.m. Eastern time. For more information regarding case management services or to refer a member, contact Provider Services at **800-450-8753**.

A member or a member designee can request case management services by calling Member Services at **800-300-8181**.

Condition Care

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

- Asthma
- Bipolar disorder
- Chronic obstructive pulmonary disease
- Coronary artery disease
- Congestive heart failure
- Diabetes
- HIV/AIDS
- Hypertension
- Major depressive disorder – adult
- Major depressive disorder – child and adolescent
- Schizophrenia
- Substance use disorder

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

Program features:

- Proactive population identification processes
- Program content is based on evidence-based national practice guidelines
- Collaborative practice models, to include physician and support-service providers in treatment planning
- Continuous patient self-management education

Ongoing communication with primary and ancillary providers regarding patient status

- Nine of our Condition Care programs are National Committee for Quality Assurance accredited and incorporate outreach, education, care coordination, and follow-up to improve treatment compliance and enhance self-care

The Anthem condition care programs are based on nationally approved evidence-based clinical practice guidelines located at providers.anthem.com/ny. You can print a copy of the guidelines right from the site, or you can request a hard copy by calling Provider Services at **800-450-8753**.

Who is Eligible?

All Anthem members with one or more of the listed conditions are eligible for condition care services.

As a valued provider, we welcome your referrals of patients who can benefit from additional education and case management support. Our case 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 stratified based on the severity of their conditions. They are provided with continuous education on self-management concepts, which include primary prevention, behavior modification, and compliance/monitoring, as well as case/care management for high-risk members. Providers are given telephonic and/or written updates regarding patient status and progress.

Condition Care Provider Rights and Responsibilities

The provider has the right to:

- Have information about Anthem services, its staff's qualifications, and any contractual relationships.

Decline to participate in or work with Anthem programs and services for their patients, if the client's contract allows.

- Be informed of how Anthem coordinates interventions and treatment plans for individual patients.
- Know how to contact the person responsible for managing and communicating with the provider's patients.
- Be supported by the organization when interacting with patients to make decisions about their healthcare.
- Receive courteous and respectful treatment from Anthem staff.
- Communicate complaints to Anthem.

Hours of Operation

Anthem case managers are registered nurses and are available from 8:30 a.m. to 5:30 p.m. Eastern time, Monday through Friday. Confidential voicemail is available 24 hours a day. The 24/7 NurseLine is available for our members 24 hours a day, 7 days a week.

Contact Information

You can call a CNDC team member at **888-830-4300**. Members and providers can find out more about our CNDC programs by visiting providers.anthem.com/new-york-provider/patient-care/condition-care.

Health Education Advisory Committee

The Health Education Advisory Committee provides advice to Anthem regarding health education and outreach-related program development. The committee strives to ensure that materials and programs meet cultural competency requirements and are both understandable to the member and address the member's health education needs.

The Health Education Advisory Committee's responsibilities are to:
Identify the health education needs of the membership based on a 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 make recommendations on health education strategies.

17 MEMBER RIGHTS, GRIEVANCES AND EXTERNAL APPEAL PROCEDURES

Members have rights and responsibilities when participating with an MCO. Our Member Services representatives serve as advocates for Anthem members. The following lists the rights and responsibilities of members.

Member Rights and Responsibilities

Members have a right to:

- Receive information about the organization, its services, its practitioners and providers, and member rights and responsibilities.
- Be treated with respect and recognition of their dignity and their right to privacy.
- Participate with practitioners in making decisions about their health care.

A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

- Voice complaints or appeals about the organization or the care it provides.

Make recommendations regarding the organization's member rights and responsibilities policy.

Members have a responsibility to:
Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.

- Follow plans and instructions for care that they have agreed to with their practitioners.

Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

The member has the right to obtain complete and current information concerning a diagnosis, treatment, and prognosis from a physician or other provider in terms the member can reasonably understand.

When it is not advisable to give such information to the member, the information shall be made available to an appropriate person acting on the member's behalf.

The member has the right to receive information from their physician or other provider that the member needs in order to give the member informed consent prior to the start of any procedure or treatment.

The member has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.

The member has the right to formulate advance directives regarding their care.

Member Grievance Procedure
Grievance: A complaint you communicate to Anthem that does not involve a Utilization Review determination.

Our grievance procedure applies to any issue not relating to a medical necessity or experimental or investigational determination by us. For example, it applies to issues or concerns the patient has regarding our administrative policies or access to providers.

Filing a Grievance
The member can contact us by phone at **800-300-8181 (TTY 711)**. The member or the member's designee has up to 180 calendar days from when they received the decision they are asking us to review to file the grievance.

When we receive the member's grievance, we will mail an acknowledgment letter within 15 business days. The acknowledgment letter will indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and we will take no discriminatory action because of your issue. We have a process for both standard and expedited grievances, depending on the nature of your inquiry.

Grievance Determination
Qualified personnel will review the member's grievance, or if it is a clinical matter, a licensed, certified, or registered healthcare professional will look into it. We will decide the grievance and notify the member within the following timeframes:

Expedited/Urgent Grievances:
By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of the grievance. Written notice will be provided within 72 hours of receipt of the member's grievance.

Standard Grievances
In writing, within 30 calendar days of receipt of the member's grievance

Assistance
If the member remains dissatisfied with our grievance determination, or at any other time the member is dissatisfied, the member may:

Contact the New York State Department of Health at **800-206-8125** or via postal mail to:

New York State Department of Health
Office of Health Insurance Programs
Bureau of Consumer Services – Complaint Unit
Corning Tower – OCP Room 1609
Albany, NY 12237

Email: managedcarecomplaint@health.ny.gov
Website: health.ny.gov

If the member needs assistance filing a grievance or appeal, the member may also contact the state-independent Consumer Assistance Program at:

Community Health Advocates
105 East 22nd Street
New York, NY 10010

Call toll-free: **888-614-5400**
Email: cha@cssny.org
Website: communityhealthadvocates.org

External Appeals

In some cases, the member has a right to an external appeal of a denial of coverage. If we have denied coverage on the basis that a service is not medically necessary (including appropriateness, health care setting, level of care or effectiveness of a covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases); or is an out-of-network treatment, the member or the member's representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for the member to be eligible for an external appeal the member must meet the following two (2) requirements:

- The service, procedure, or treatment must otherwise be a covered service under this contract; and

In general, the member must have received a final adverse determination through our internal appeal process. But the member can file an external appeal even though the member has not received a final adverse determination through our internal appeal process if:

- We agree in writing to waive the internal appeal. We are not required to agree to the member's request to waive the internal appeal; or
- The member can file an external appeal at the same time as the member applies for an expedited internal appeal; or
- We fail to adhere to utilization review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to the member, and we demonstrate that the violation was for good cause or due to matters beyond our control and the violation occurred during an ongoing, good faith exchange of information between the member and us).

Member's Right to Appeal a Determination That a Service Is Not Medically Necessary
If we have denied coverage on the basis that the service is not medically necessary, the member may appeal to an external appeal agent if the member meets the requirements for an external appeal in the above paragraph.

Member's Right to Appeal a Determination That a Service Is Experimental or Investigational
If we have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), the member must satisfy the two (2) requirements listed under the External Appeals section above and the member's attending physician must certify that the member's condition or disease is one for which:

1. Standard health services are ineffective or medically inappropriate; or
2. There does not exist a more beneficial standard service or procedure covered by us; or
3. There exists a clinical trial or rare disease treatment (as defined by law).

In addition, the member's attending physician must have recommended one (1) of the following:

1. A service, procedure, or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to the member than any standard covered service (only certain documents will be considered in support of this recommendation – the member's attending physician should contact the State for current information as to what documents will be considered or acceptable); or
2. A clinical trial for which the member is eligible (only certain clinical trials can be considered); or
3. A rare disease treatment for which the member's attending physician certifies that there is no standard treatment that is likely to be more clinically beneficial to the member than the requested service, the requested service is likely to benefit the member in the treatment of the member's rare disease, and such benefit

outweighs the risk of the service. In addition, the member's attending physician must certify that the member's condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, the member's attending physician must be a licensed, board-certified, or board-eligible physician qualified to practice in the area appropriate to treat the member's condition or disease. In addition, for rare disease treatment, the attending physician may not be the member's treating physician.

Member's Right to Appeal a Determination That a Service is Out-Of-Network
If we have denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, the member may appeal to an External Appeal Agent if the member meets the two (2) requirements listed under the External Appeals section above, and the member has requested preauthorization for the out-of-network treatment.

In addition, the member's attending physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

For purposes of this section, the member's attending physician must be a licensed, board-certified, or board-eligible physician qualified to practice in the specialty area appropriate to treat the member for the health service.

Member's Right to Appeal an Out-Of-Network Pre-Authorization Denial to a Non-Participating Provider
If we have denied coverage of a request for authorization to a non-participating provider because we determine we have a participating provider with the appropriate training and experience to meet the member's particular healthcare needs who is able to provide the requested healthcare service, the member may appeal to an External Appeal Agent if the member meets the two (2) requirements listed under the External Appeals section above.

In addition, the member's attending physician must: certify that the participating provider recommended by us does not have the appropriate training and experience to meet the member's particular healthcare needs; and recommend a non-

participating provider with the appropriate training and experience to meet the member's particular health care needs who is able to provide the requested health care service.

For purposes of this section, the member's attending physician must be a licensed, board-certified, or board-eligible physician qualified to practice in the specialty area appropriate to treat the member for the health service.

Member's Right to Appeal a Formulary Exception Denial
If we have denied the member's request for coverage of a non-formulary prescription drug through our formulary exception process, the member, the member's designee, or the prescribing health care professional may appeal the formulary exception denial to an External Appeal Agent. See the Prescription Drug Coverage section of this contract for more information on the formulary exception process.

External appeal process
The member has four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal appeal process to file a written request for an external appeal. If the member is filing an external appeal based on our failure to adhere to claim processing requirements, the member has four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through our internal appeal process or our written waiver of an internal appeal. The member may also request an external appeal application from the New York State Department of Financial Services at **800-400-8882**. Submit the completed application to the Department of Financial Services at the address indicated on the application. If the member meets the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

The member can submit additional documentation with the member's external appeal request. If the External Appeal Agent determines that the information the member submitted represents a material change from the information on which we based our denial, the External Appeal Agent will share this information with us in order for us to exercise our right to reconsider our decision. If we choose to exercise this right, we will have three (3) business days to amend or confirm our decision. Please note that in the case of an expedited external appeal (described below), we do not have a right to reconsider our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of the member's completed application. The External Appeal Agent may request

additional information from the member, the member's physician, or us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify the member in writing of its decision within two (2) business days.

If the member's attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to the member's health; or if the member's attending physician certifies that the standard external appeal time frame would seriously jeopardize the member's life, health or ability to regain maximum function; or if the member received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, the member may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of the member's completed application. Immediately after reaching a decision, the External Appeal Agent must notify the member and us by telephone or facsimile of that decision. The External Appeal Agent must also notify the member in writing of its decision.

If the member's internal formulary exception request received a standard review through our formulary exception process, the External Appeal Agent must make a decision on the member's external appeal and notify the member or the member's designee and the prescribing health care professional within 72 hours of receipt of the member's completed application. If the External Appeal Agent overturns our denial, we will cover the prescription drug while the member is taking the prescription drug, including any refills.

If the member's internal formulary exception request received an expedited review through our formulary exception process, the External Appeal Agent must make a decision on the member's external appeal and notify the member or the member's designee and the prescribing health care professional within 24 hours of receipt of the member's completed application. If the External Appeal Agent overturns our denial, we will cover the prescription drug while the member suffers from a health condition that may seriously jeopardize the member's health, life, or ability to regain maximum function or for the duration of the member's current course of treatment using the non-formulary prescription drug.

If the External Appeal Agent overturns our decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment, we will provide coverage subject to the other terms and conditions of this contract. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical

trial, we will only cover the cost of services required to provide treatment to the member according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-healthcare services, the costs of managing the research, or costs that would not be covered under this contract for non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both the member and us. The External Appeal Agent's decision is admissible in any court proceeding.

Member Responsibility in External Appeal Process
It is the member's responsibility to start the external appeal process. The member may start the external appeal process by filing a completed application with the New York State Department of Financial Services. The member may appoint a representative to assist the member with the member's application; however, the Department of Financial Services may contact the member and request that the member confirm in writing that the member has appointed the representative.

Under New York State law, the member's completed request for external appeal must be filed within four (4) months of either the date upon which the member receives a final adverse determination, or the date upon which the member receives a written waiver of any internal appeal, or our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

18 APPENDIX A — FORMS

Visit our provider self-service website at providers.anthem.com/ny and select **Resources** > **Forms** for the most up-to-date copies of all Anthem forms. If you do not have access to the website, call our Provider Services team at **800-450-8753**.

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 a separate company providing utilization review services on behalf of the health plan.

Provider Services: 800-450-8753
https://providers.anthem.com/ny

To learn more about applying for health insurance, including Medicaid, Child Health Plus, Essential Plan, and Qualified Health Plans through the NY State of Health, The Official Health Plan Marketplace, visit **nystateofhealth.ny.gov** or call **855-355-5777**. Independent licensees of the Blue Cross Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.