Anthem • New York

Managed Long-Term Care Plan

Provider Manual

Anthem

NYBCBS-CD-PM-052913-24

Dear Provider Partner,

Welcome to Anthem Blue Cross and Blue Shield (Anthem) Managed Long-Term Care (MLTC) Plan! We are thrilled to have you with us and are grateful for your participation in our network.

Anthem is a New York State-approved Medicaid MLTC Plan operating in the five counties of New York City, as well as Nassau, Suffolk, and Westchester counties. We are a 5-star rated MLTC plan, according to the New York Department of Health's 2022 Managed Long-Term Care Consumer Guide for NYC. Anthem is committed to helping our members stay healthy, safe, and living independently in the comfort of their own homes.

This is only possible through our partnership with you. Your medical services are an essential component of the high-quality coordinated care we strive to provide our members. Only with your assistance can we ensure this care is the best possible, and that it's always delivered in a caring manner that celebrates and respects our members' cultural and linguistic diversity.

The MLTC provider manual is your guide to this partnership. It contains useful information about the Anthem program and guidance regarding important regulations, policies, and procedures. Additional copies of the manual are available on request, and you will be notified regarding any changes through electronic notifications, quarterly electronic provider newsletters and, when needed, through formal mailings. Please read and retain these updates.

If you have any questions regarding the manual or its contents, please contact us at **929-946-6500**.

Thanks again for participating in our network. We look forward to working with you and yourstaff.

Sincerely,

Anthem

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Introduction

Anthem Blue Cross and Blue Shield (Anthem) Managed Long-Term Care (MLTC) Plan is a New York State-approved Managed Long Term Care Plan designed to assist senior and disabled adults to live safely and independently in the comfort of their own homes while maintaining their health and wellbeing.

Service Area

Anthem operates in the five counties of New York City, as well as in Nassau, Suffolk, and Westchester counties.

Eligibility Criteria

To enroll in Anthem, individuals must be:

- Medicaid-eligible and aged 18 years or older.
- Residents of Anthem service area.
- Determined eligible for MLTC according to an eligibility assessment tool designated by the New York State Department of Health (NYSDOH).
- Capable at the time of enrollment of returning to and remaining in their homes and communities without jeopardy to their health and safety, a determination based upon criteria provided by the New York State DOH, and
- In need of at least one of the following services for more than 120 days:
    - Nursing services in the home
    - Therapies in the home
    - Home health aide services
    - Personal care services in the home
    - Adult day health care
    - Private duty nursing, or
    - Consumer Directed Personal Assistance Services (CDPAS)

Please note that Anthem does not take into consideration an applicant's potential need for acute hospital inpatient services or nursing home during this 120-day period for assessing an applicant's eligibility for enrollment.

Program Goals and Care Management

Anthem's objective is to materially and measurably improve the health and quality of our member's lives through the assistance of our Care Management Teams. These teams are dedicated groups of professionals who work with PCPs and members to coordinate health and long-term care services. Services are determined according to an individualized care and service plan, itself a product of a comprehensive assessment of member needs and information obtained from member healthcare providers. The Care Management team works with participating providers in the Anthem network to ensure that services are of high quality and provided in a respectful manner.

The Care Management team consists of one care manager (a registered nurse), a social worker, and a service coordinator.

The Care Management team's primary responsibilities are:

- Initial assessment of member.
- Management of covered services and coordination of covered services with both noncovered services and those services provided through community resources and informal supports.
- Development of individual care plans and healthcare goals in consultation with both member and their informal supports.
- Ensuring healthcare goals are specified, including the types and frequencies of authorized covered services and noncovered services necessary to maintain the care plan.
- Monitoring the progress of members to ensure services provided are appropriate and in accord with the care plan.
- Reassessment of members as necessary, and no less frequently than once every 12 months.
- Update of member plan of care as warranted by the member's condition, and in any event at least once every 12 months.
- Evaluating whether care plans continue to meet member needs.

- When sharing confidential medical and treatment plan information with providers, ensuring that all applicable state and federal laws and regulations are followed.
- Generating and receiving referrals from providers.
- Supplying members with written notification of authorized services.
- Supplying providers with service orders and authorizations.
- Enlisting the involvement of community organizations that enhance the health and well-being of members, and
- Ensuring the care management record meets all applicable professional standards.

Covered Services and Noncovered Services

Anthem offers a wide range of long-term care and supportive services as part of its covered benefits. Covered benefits are those services paid for by Anthem. Noncovered services are not paid for by Anthem, but billed directly to Medicaid, Medicare, and other third-party payers by the provider. Such services may be included in a member's plan of care, and are coordinated by the Care Management team.

Covered Services (Covered by MLTC capitation)[1]	**Noncovered Services (Billed Medicaid fee- for-service)**
Care Management	Inpatient Hospital Services
Nursing Home Care	Outpatient Hospital Services
Home Care: • Nursing • Home Health Aide • Physical Therapy (PT) • Occupational Therapy (OT) • Speech Pathology (SP) • Medical Social Services	Physician Services including services provided in an office setting, a clinic, a facility, or in the home. [2]
Adult Day Health Care	Laboratory Services
Personal Care	Radiology and Radioisotope Services
DME, including Medical/Surgical Supplies, Enteral and Parenteral Formula[3], and Hearing Aid Batteries, Prosthetics, Orthotics and Orthopedic Footwear	Emergency Transportation
Personal Emergency Response System	Rural Health Clinic Services
Podiatry	Chronic Renal Dialysis
Dentistry	Mental Health Services
Optometry/Eyeglasses	Alcohol and Substance Abuse Services
PT, OT, SP or other therapies provided in a setting other than a home.	OPWDD Services
Audiology/ Hearing aids	Family Planning Services
Respiratory Therapy	Prescription and Non-Prescription Drugs Compounded Prescriptions
Nutrition	All other services listed in the Title XIX State Plan
Private Duty Nursing	
Consumer Directed Personal Assistance Services (CDPAS)	
Services Provided Through Care Management	
Home Delivered Congregate Meals	
Social Day Care	
Social and Environmental Supports	

1 The capitation payment includes applicable Medicare coinsurance and deductibles for benefit package services. Any of the services listed in this column when provided in a diagnostic and treatment center would be included in and covered by the capitation payment.

2 Includes nurse practitioners and physician assistants acting as *physicianextenders*.

3 Enteral formula limited to nasogastric, jejunostomy, or gastrostomy tube feeding; or treatment of an inborn error of metabolism.

Provider Participation in the Anthem Network

Providers must complete Anthem credentialing and approval process to participate in the network. Participating providers agree to deliver quality services to our members, to comply with Anthem contractual and program requirements, and to cooperate fully with Anthem in ensuring services meet member needs.

Provider Welcome and Orientation

Participating providers receive a Welcome Letter, Anthem Provider ID, a copy of the provider manual, and information regarding the orientation requirement.

Anthem believes members receive the best care when Anthem and its providers work in true partnership with each other. The orientation establishes a foundation for this partnership, ensuring providers are properly introduced to Anthem values and approach to collaboration. Additional subjects covered in orientation include MLTC operational details, contract requirements, policies and procedures affecting the provider's provision of service, and the provider's role in maintaining and improving the member's health, safety, independence, and well-being.

Anthem expects orientation and accompanying training to be completed within three months of a provider's credentialing by Anthem. The Provider Network Relations Department will schedule on-site meetings for new providers when applicable.

Participating Provider Rights

Anthem provider partners have these rights:

- Prompt response by Anthem to any inquiry or request for assistance
- Participation in member care planning and discussion
- To request authorization for services on a member behalf, and to file an appeal if denied
- Access to all member information necessary to provide service
- To report Anthem to the appropriate regulatory body if the provider believes Anthem is unduly limiting member access to care or otherwise undermining it, and
- Prompt payment for services rendered

Participating Provider Responsibilities

Participating as a provider in the Anthem network entails responsibilities, many of which are listed below. Note that the list is not all-inclusive. Please refer to the Anthem *Provider Agreement*, the MLTC contract, and regulations governing the MLTC program to gain a comprehensive understanding of provider responsibilities.

Provider responsibilities include:

- Providing quality care for Anthem members, including:
    - Providing care within the scope of practice and in accordance with Anthem access, quality, and participation standards
    - Adhering to Anthem *Clinical Practice Guidelines* and complying with Anthem Service Standards
    - Providing care of consistent quality regardless of a member age, race, sex, religious background, national origin, disability, sexual orientation, health status, or marital status
    - Ensuring that employees or subcontractors are not on State or Federal exclusion lists and that they fully comply with all applicable laws, regulations, applicable DOH and CMS instructions, and Anthem contractual requirements;
    - Compliance with the *Americans with Disabilities Act* (*ADA*) guidelines set forth by the NYSDOH, which require that no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or denied access to the benefits of services, programs or activities of a public entity, or otherwise subjected to discrimination by such an entity. Furthermore, Anthem providers are expected to meet the access needs of member with disabilities. Physical accessibility is not limited to entry to a provider site, but also includes access to services within the site, and
    - Making a good faith effort to provide member services in a culturally competent manner, including provisions for member with limited English proficiency or reading skills, as well as provision for those of diverse cultural and ethnic backgrounds.

- Notifying Anthem Provider Network Relations Department of updates to your information, and especially of any changes that affect your ability to render service. This includes, but is not limited to:
  - Changes in provider's name and Tax ID number(s)
  - Changes in provider's address, zip code, telephone, fax, or email
  - Changes in provider's billing address
  - Changes in languages spoken in the provider's office
  - Changes in wheelchair accessibility
  - Changes in provider's health (if individual practitioner)
  - Changes in provider's licensing or permit
  - Any action or investigation initiated by a regulatory agency, and
  - Any malpractice action
- Cooperating with Anthem in meeting regulatory requirements and addressing feedback from members:
  - Ensure effective and efficient coordination of member care
  - Resolve member grievances
  - Participate with external review programs
  - Implement quality improvement initiatives
  - Address performance issues identified from Anthem *Member Satisfaction Surveys*
  - Provide regular and timely report on performance and quality of care
  - Ensure timely completion of re-credentialing and meet any applicable participation criteria required by DOH or CMS
  - Ensure proper fraud, waste and abuse detection and prevention, and
  - Ensure timely, complete, and accurate regulatory reporting
- Complying with Anthem authorization and payment polices and guidelines, including:
  - Obtaining physician orders when required
  - Obtaining prior authorization for services when required
  - Undergoing concurrent review aimed at ensuring medical necessity of services
  - Following preadmission testing guidelines if applicable
  - Notifying Anthem within 48 hours if any unauthorized *urgent* services are provided
  - Following guidelines related to submission of claims and other encounter data, and
  - Cooperation with claims payment review
- Complying with regulatory, contractual, and professional standards of practice, as well as Anthem policies and procedures. Note that Anthem will inform you at least 30 days prior to any material modification of these policies via the Anthem website or by other reasonable means within Anthem sole discretion.
- Notifying Anthem immediately if:
  - A clinical issue or serious concern is identified;
  - There is a change in member status;
  - A member refuses service;
  - You are unable to access the member home or provide service for any reason, or
  - Any complaint is made by or on behalf of a member.
- Maintaining confidentiality and agreeing not to disclose to any third-party Anthem trade secrets, intellectual property, and other confidential information without the prior written consent of Anthem, and
- Respecting and safeguarding Anthem member rights.

Providing Service for Anthem Members

Member Rights and Responsibilities

Anthem members have certain rights and protections. As an Anthem provider, you have the responsibility to respect and safeguard these rights.

Specifically, Anthem members have the right to:

- Treatment without discrimination based on race, color, religion, gender, national origin, disability, sexual orientation, or source of payment
- Participate with the care manager (RN), physicians, and other participating providers in making decisions about their healthcare
- A non-smoking environment
- Receive considerate and respectful care in a clean and safe environment
- Receive, upon request, a list of healthcare providers participating in the Anthem provider network
- Choose and/or change their healthcare and other participating providers
- Be assured that participating healthcare providers have the qualifications stated in Anthem *Credentialing Policies and Procedures*
- Know the names, positions, and functions of any participating provider's staff and to refuse their treatment, examination, or observation
- Obtain from Anthem and their providers comprehensive information about their Plan of care and the benefits/services covered and/or provided, regardless of cost or benefit coverage. If a member is not self-directing, the information will be made available to a person who has been designated to act on that person's behalf
- Obtain this information, verbally and in writing, in a language they can understand
- Receive medically necessary care
- Timely access to care and services
- Privacy about their medical record and when they receive benefits or services
- Get information on available benefit/service options and alternatives presented in a manner and language they understand
- Obtain, at any time, a copy of their healthcare records, as well as the right to ask that these records be amended or corrected
- Be treated with respect and dignity
- Take part in decisions about their healthcare, including the right to refuse benefits and services
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Be told where, when, and how to get the services they need from their managed long-term plan of care, including how they can get covered benefits from out-of-network providers if they are not available in Anthem network
- Obtain information necessary to give informed consent prior to the start of any treatment or care
- Complain to the NYSDOH or the Local Department of Social Services, to use the New York State Fair Hearing System, and in some instances request a New York State External Appeal
- Appoint someone to speak for them about their care and treatment, and to be present and take part in any discussions about their care and the benefits and services provided, and
- Make advance directives and plans about their care

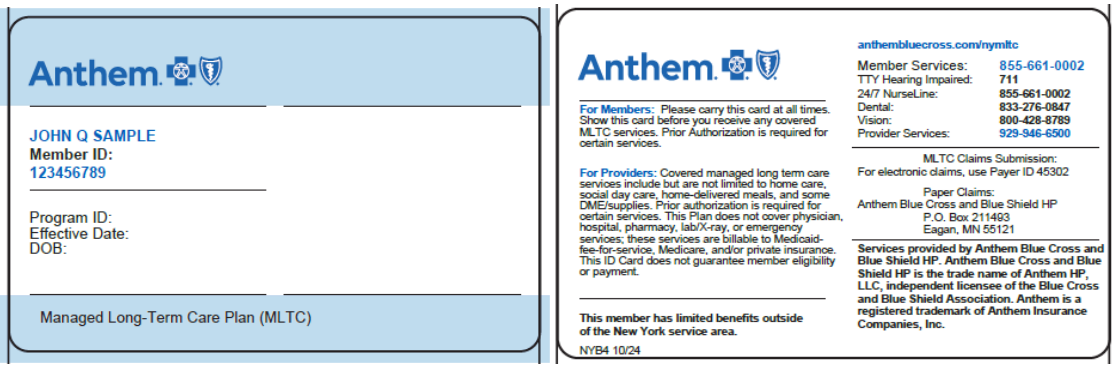
Anthem members also have responsibilities. Specifically, they are required to:

- Provide Anthem, its participating physicians, and other providers with accurate and relevant information about their medical history and health so that appropriate treatment and care can be rendered.
- Keep scheduled appointments or, when cancelling them, to give as much notice as possible in accordance with the provider's guidelines for cancellation.
- Update their Anthem record with accurate personal data, including changes in name, address, phone number, and additional health insurance carriers.
- Treat with consideration and courtesy all Anthem personnel, and the personnel of any agency or healthcare provider to which they are referred.
- Be actively involved in their own healthcare by seeking and obtaining information, by discussing treatment options with their Care Management team, and by making informed decisions about their healthcare.
- Follow plans and instructions for care that they have agreed to with their practitioner.
- Understand their health conditions and participate in developing mutually agreed upon treatment goals, to the degree possible.

- Understand Anthem benefits, policies, and procedures as outlined in their *Member Handbook*, including policies related to prior approval for all services that require such approval.
- Request and receive all covered benefits through Anthem.
- Contact Anthem when they need help or have a question.
- Follow the plan of care that was agreed upon and request changes as needed
- Make every effort to pay Anthem any Medicaid surplus amount owed;
- Maintain Medicaid eligibility, and
- Notify Anthem when they go away or are out of town

Member Eligibility and Verification of Coverage

Every Anthem member will receive an ID card that will have the member name and identification number. This card, which identifies an individual as an Anthem member, should be presented by the member when seeking covered services.



However, possession of the ID card does not guarantee the member's eligibility for service on the day the service is rendered. It is the provider's responsibility to verify the eligibility of each member prior to rendering services through electronic, telephonic, or other means Anthem makes available. Member eligibility can be checked through E-PACES or by calling the Anthem Provider Service Line at **929-946-6500**.

Anthem should be contacted by providers to be made aware of any information relating to the possible ineligibility of any member to participate in Anthem MLTC Program and/or receive covered services through Anthem. This includes reporting any individual claiming to be a member who does not present an ID card.

Please note that Anthem is not liable for services rendered to individuals ineligible for covered services at the time services are rendered.

Non-English Speaking or Disabled Members

Anthem is committed to ensuring that all its member have unfettered access to its services and that the experience of non-English speaking and/or disabled member is a positive one. Anthem MLTC's diverse staff provides language assistance, and a supplemental language assistance line is available to fill any gaps. Anthem also accommodates visually impaired and hearing impaired members in compliance with the requirements of the *ADA*.

Providers are similarly expected to address the language needs of Anthem members, as well as the special needs of its visually impaired and hearing impaired members.

Service Referrals and Authorizations

Service authorizations are care decisions based on a comprehensive member assessment, medical necessity, clinical guidelines, and with input from the member's, family, physician, and other persons involved in the care of the member. Upon development or update of the person-centered plan of care, a service plan is developed. This service plan details all covered services to be provided to the member and specifies the scope, duration, and frequency of the services. The Care Management team works with the member to select the appropriate providers to render services, makes service referrals, and ensures that authorization is in place for providers to render the services.

For services requiring prior authorization, Anthem will send service authorizations to providers via the Anthem MLTC Provider Portal. Providers are advised to check the portal regularly to obtain updated information on service authorizations. It is the responsibility of the provider to ensure authorizations are in place prior to rendering services.

Transition of Care for Fee-For-Service Members in Mandatory Counties

There are *transition/continuity of care* requirements for each Anthem member who is receiving community-based long-term services and supports for the following:

- Personal Care Services
- Consumer Directed Personal Care (CDPAS)
- Home Health Services
- Private Duty Nursing
- Adult Day Health Care, and
- Lombardi (LTHCP)

All members receiving such services at the time of enrollment must continue to receive those services under their pre-existing service plan for at least 90 days after enrollment or until a care assessment has been completed by Anthem, whichever is later. In addition, the recipient/worker relationship is to be preserved for the same 90-day period.

Members and providers acting on behalf of member have the right to file an appeal (standard or expedited, if warranted) for any reduction, suspension, denial, or termination of previously authorized services. Members have the right to continuation of authorized services pending the appeal and the right to a fair hearing if Anthem renders an adverse determination (either in whole or in part) on appeal.

Consequently, any individual receiving community-based long-term services and supports via fee-for-service Medicaid who is enrolling under any circumstance will receive 90 days continuity of care from Anthem. Further, if there is an appeal or fair hearing as a result of any proposed reduction, suspension, denial, or termination of previously authorized services, Anthem will comply with appropriate decisions stemming from these proceedings. Finally, if the member requests a State Fair Hearing to review Anthem decision on appeal, Anthem will provide aid-to-continue until the Fair Hearing decision is issued.

Services Requiring Authorization and Physician Orders

All covered services require prior authorization **except** for the following:

- Routine dental care referrals and services covered under Liberty Dental
- Routine vision exam and services covered under Superior
- Routine podiatry exam and services

The following covered services require a physician’s order as part of the prior authorization process:

- ADHC
- DME (ambulation devices, not for home safety equipment)
- Home health care
- Medical supplies (that require ongoing refill)
- Prosthesis/Orthotics
- Nursing home care

- Personal care
- Rehabilitation services
- Respiratory therapy services
- Private duty nursing
- CDPAS

Covered Services	Authorization	Physician Order
Care Management	None Required	None Required
Nursing Home Care	Required	Required
Home Care • Nursing • Home Health Aide • Physical Therapy (PT) • Occupational Therapy (OT) • Speech Pathology (SP) • Medical Social Services	Required	Required
Adult Day Health Care	Required	Required
Personal Care	Required	Required
Consumer Directed Personal Care	Required	Required
DME, including Medical/Surgical Supplies, Enteral and Parenteral Formula, and Hearing Aid Batteries, Prosthetics, Orthotics and Orthopedic Footwear	Required	Required
Personal Emergency Response System	Required	None Required
Podiatry	None Required	None Required
Dentistry	None Required	None Required
Optometry/Eyeglasses	None Required	None Required
Rehabilitation Services: Physical Therapy, Occupational Therapy, & Speech Therapy	Required	Required
Audiology/ Hearing aids	Required	None Required
Respiratory Therapy	Required	Required
Nutrition	Required	None Required
Private Duty Nursing	Required	Required
Home Delivered or Congregate Meals	Required	None Required
Social Day Care	Required	None Required
Social and Environmental Supports	Required	None Required

Requesting Authorization

Providers may request authorizations on behalf of a member, including an authorization for a new service or a request for a concurrent review in order to change an existing service being provided. Requests may be made either verbally or in writing.

Immediately upon receipt of the request, the care manager will reach out to the provider to discuss the circumstances informing the request in order to determine whether it should be handled within the standard time frame or on an expedited time frame.

Time Frames for Anthem Decision on Authorization Requests

A review will be performed on an expedited time frame if Anthem or the member provider believes a delay in service authorization could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function.

The required time frames for processing authorization requests are as follows.

- **Prior Authorization:** If the request is for a *new service* and the care manager determines that the time frame should be
  - ***Standard***, Anthem will make a determination within three business days of its receipt of necessary information, but no more than 14 days from the receipt of the request;
  - ***Expedited***, Anthem will make a determination within 72 hours of receipt of necessary information.

- **Concurrent Review:** If the request is to *increase the amount* of service already being provided and the care manager determines that the time frame should be
  - ***Standard***, Anthem will make a determination within one business day of receipt of necessary information, but no more than 14 days from receipt of the request;
  - ***Expedited***, Anthem will make a determination within one business day of receipt of necessary information, but no later than 72 hours from the receipt of the request.

    - If the request is for home health care services following an inpatient admission, the request will be handled as expedited, and the determination will be made within one business day after receipt of necessary information, but no later than 72 hours after receipt of the request. If home care services following an inpatient admission stay are requested and the next day is a Friday/holiday, a determination will be made within 72 hours.
    - Extensions of up to 14 calendar days may be requested by the member or by a provider on the member's behalf (written or verbal). Anthem may also initiate an extension if it can justify the need for additional information and if the extension is in the member's interest. In all cases, the extension reason must be well-documented.

An extension may be initiated for additional documentation and must be in the best interest of the member. The reason for the extension is documented on the notice.

- The requested service must be medically necessary (necessary to prevent, diagnose, correct, or cure conditions in the member that cause acute suffering, endanger life, result in illness or infirmity, interfere with the member's capacity for normal activity, or threaten some significant handicap)
- The requested service must reasonably be expected to achieve its purpose
- The requested service will allow the member to remain healthy and in their home safely

In making a determination for a service authorization request, the care manager may consult with the member's physician, other service providers, the care management supervisor, the Anthem medical director, and/or clinical consultants/peer reviewers, as necessary prior to submitting the service authorization request to the utilization management department for the UM determination.

Use of Clinical Consultants or Clinical Peer Reviewers

Following the latest clinical and regulatory guidelines the utilization nurse will make decisions on the authorization requests. They will consult with stakeholders on a necessary basis.

Authorization for Out-of-Network Use

Anthem will grant a request for service with an out-of-network provider if any of the following is true:

- The member is newly enrolled in Anthem and has been receiving services from the out-of-network provider, thus qualifying for authorization for services up to 90 days for transition/continuity of care, for plan closures 120 days of continuity of care and the provider agrees to accept Anthem reimbursement as payment in full and abide by Anthem policies and procedures
- The member's provider leaves Anthem network, thus qualifying the member for authorization of services for up to 90 days from notice to the member to transition them to another Anthem provider, so long as the provider agrees to accept the same payment rate and abide by Anthem policies and procedures as in the past
- The member is in a medical emergency situation and the provider's service is needed to stabilize the member's status and prevent harm, or if it is impractical to arrange for an Anthem provider to render the service
- There's no Anthem provider with the required expertise or qualification, or such provider is not readily accessible or available to the member

All out-of-network authorizations will be granted for as short a period of time as possible to allow time to find an in-network alternative or in order to establish a provider contract with the out-of-network provider. This will mean either a one-time authorization for certain services (for example, DME, orthotics, prosthetics, home repairs) or, for services that require continued care (for example, home health care and personal care), a **maximum of one month of service authorization** at a time.

Emergency/Urgent Situations

Members who contact Anthem indicating they are experiencing a medical or behavioral emergency are instructed to contact **911** or to go to the nearest emergency facility. Covered services that are medically necessary to stabilize or treat an emergency condition do not require prior authorization. Anthem does require member to notify Anthem within three days of the receipt of such emergency services so that Anthem can review the member care plan for any needed adjustments. If an adjustment to services is appropriate, the care plan will be revised accordingly.

To the extent that Anthem is involved in arranging for the service in the emergency, authorization of the service provision will be for a period covering three days. For the service to continue, an authorization request must be made.

If a provider, member, or member's representative on behalf of the member, calls Anthem to request a service and there appears to be grounds for urgency, the request will be handled as an expedited request. This means we will:

- Request information needed in order to make a determination, and
- Send the member an acknowledgement of service authorization request that also confirms the request is being handled as an expedited request, and lists any information required.

Authorizations for CDPAS

Providers should use the Physician's Order for Personal Care/Consumer Directed Personal Assistance Services Form. Please email it to MLTCCDPAS@Anthem.com.

A sample of the *Physician's Order for Personal Care Form* can be found in the back of this manual (***Exhibit A***).

Participating providers in Anthem network are required to provide service to members in accordance with standards set by Anthem except when a longer time frame is required by the member. The standards are outlined below.

Service	Standard
Adult Day Health Care	Placement must occur within 14 days
Audiology	Standard visit within 7 days Emergency visit within 48 hours
Consumer Directed Personal Care	Initial visit must occur on the date and time specified by Anthem
Dentistry	Standard visit within 28 days Emergency visit within 24 hours
DME/Supplies	Delivery of supplies must occur within 72 hours unless custom order
Home Health Care	Initial visit must occur within 24 hours
Meals (Home/Congregate)	Date and time specified by Anthem
Nursing Home	Facility Placement must occur as quickly as possible
Nutritional Counseling	Service must be provided within 14 days
Optometry	Standard visit within 7 days Emergency visit within 24 hours
Orthotics & Prosthetics	Measurements taken within 14 days
Personal Care	Initial visit must occur on the date and time specified by Anthem
Podiatry	Standard visit within 7 days

Service	Standard
	Emergency visit within 24 hours
Private Duty Nursing	Date and time specified by Anthem
Rehabilitation Services (PT, OT, ST)	Initial visit must occur within 72 hours (in home)
Respiratory Therapy	Initial visit within 7 days (not in home)
Social Day Care	Initial visit must occur within 24 hours
Social & Environmental Supports	Placement must occur within 14 days
Social Work Services	Delivery within 14 days unless custom ordered

Specific Requirements by Provider Type

Participating providers are required to comply with all regulatory and professional standards of practice. They are also responsible for acquiring physician orders whenever required by law, as well as for determination of medical necessity and/or third-party reimbursement. The care manager and interdisciplinary care team may assist in obtaining orders if the participating provider has been unsuccessful, but primary responsibility for obtaining orders is the participating provider's. Additional responsibilities by provider type are listed below.

Home Care Participating Provider Responsibilities:

- Obtain physician orders
- Develop the home aide plan for requested services
- Supervise the aide in accordance with state and federal regulations
- Ensure that individuals who are both family members of Anthem members and aides are **not** assigned to handle the care of the Anthem family member
- Notify member in advance of the name(s) of any assigned staff
- Notify member in advance of any need for replacement of staff and of the name(s) of replacement staff
- Confirm the daily attendance of staff. To assure the safety of our members, Anthem recommends that all home care participating providers implement an electronic attendance program in addition to any manual verification programs. Agencies not utilizing electronic attendance programs must verify attendance of staff providing service to Anthem members on a daily basis, and agency protocol on aide attendance verification must be made available to Anthem upon request
- Submit evaluation and progress notes within one business day of request by Anthem for authorization purposes and within five business days of request for quality assurance purposes
- Fully cooperate with the Anthem Care Management Department's inquiries regarding a member's status, even if a given episode of care doesn't result in any payment by Anthem to the participating provider. Such cooperation may be verbal or written
- Immediately notify Anthem whenever a clinical issue or serious concern regarding a member is identified. This includes, but is not limited to, falls, hospitalizations, changes in member status, member refusals of service, any inability to access a member's home to provide service for any reason. Participating providers are also responsible for relaying any complaint made by or on behalf of the member to Anthem

Nursing Home/Skilled Nursing Facility (SNF) Participating Provider Responsibilities:

- In the context of a short-term stay (up to six months):
  - Determine the type of health insurance coverage the prospective resident has and whether or not the SNF is authorized to serve the member
  - Submit initial evaluations, assessments, and plans of care (including short and long-term goals) within one week of admission. Subsequent progress notes and/or plan of care updates should be submitted at least monthly or within one business day of request by Anthem for authorization purposes
  - Obtain authorization for any covered service outside of the daily rate, and
  - Assist in the Medicaid recertification process

- In a long-term placement context:
  - Determine eligibility for Institutional Medicaid and other third-party coverage, as well as whether the SNF is authorized to serve the member
  - Submit conversion applications for member placed in long-term care
  - Identify any admission as an MLTC admission
  - Collect the Net Available Monthly Income (NAMI), which will later be deducted from payments
  - Submit resident monthly summaries to the Anthem care manager
  - Include the Anthem care manager in case conference
  - Obtain authorization for any covered service outside of the daily rate, and
  - Assist in the Medicaid recertification process.

Note: Anthem member must be eligible for Institutional Medicaid to remain in an SNF for long term care.

Adult Day Health Care Provider Responsibilities:

- Be able to provide:
  - Clinic visits, defined as care or an occasion of service less than three hours in duration, or
  - Part day care, defined as clinic care longer than three hours but shorter than five hours, or
  - Full day care, defined as clinic care longer than hours but shorter than 24 hours, or
  - Evening care, defined as clinic care provided after 5 P.M., but not including an overnight stay, or
  - Night care, defined as clinic care for less than 24 hours in a day in a SNF and including, as a minimum, an overnight stay in the facility.
- Arrange for indirect or direct provision of the following services to members:
  - Medical services, including admission and medical history, physical examinations, consultations by medical specialists when needed, and necessary orders for medication, diet, physical therapy, occupational therapy, and supportive services
  - Nursing services, under the direct supervision of a registered professional nurse, based on periodic and continuing evaluations of each member need for nursing care
  - Dental care, provided in accordance with State guidelines for dental care
  - Rehabilitation therapy and speech-language pathology services
  - Pharmaceutical services, including supervision for use and administration of prescribed drugs, as appropriate, and
  - Supportive services, including laboratory, X-ray, and other such services
- Place members within 14 days of request
- Develop or arrange for the development of a written review and evaluation plan within 30 days for each member
- Review and evaluate the member status no less than yearly, and more often as indicated by changes in the conditions or circumstances of the member
- Develop and maintain a health record for each member that compiles current health reports and information pertaining to a member care. The record should include all planning, and should be promptly entered, dated, and signed by the individual providing the information or prescribing the service. It should also be kept in a place conveniently accessed by authorized staff.

Adult Social Day Care Provider Responsibilities:

- Comply with New York State Office of Aging Social Adult Day Care Regulations.
- Comply with all HCBS Settings Final Rules.
- Perform a psychosocial assessment to determine member's functional capability and impairment.
- Reassess functional capacity when appropriate, including whether the member still has the capacity for safe participation in the program.
- Develop individual service plans for consumers, caregivers, and informal supports. These should:
  - Be developed within 30 days
  - Be reviewed at least semi-annually
  - Promote the highest possible functional level
  - Build on existing capabilities and/or focus on development of new capabilities or compensation, and
  - Specify expected outcomes
- Provide services to functionally, physically, or cognitively impaired individuals that must include:
  - Socialization
  - Supervision
  - Social Care Assistance
- Provide nutritious meals and snacks as scheduled and upon participants' request.

Please note:

- Prior to submitting claims for services provided, the SADC program must reconcile daily attendance sheets with member's scheduled attendance. Only claims for those days a member actually attended the SADC program should be submitted for payment. Claims submitted for days that member did not attend the SADC program will be considered fraudulent and will be reported to the State and other appropriate authorities.

Podiatry Services

Services include routine foot care when the member's physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot or when performed as a necessary and integral part of the treatment of diabetes, ulcers and

infections. Covered podiatry services exclude routine foot care, the treatment of corns and calluses, the trimming of nails and other hygienic care of the feet in the absence of a pathological condition, unless precertified.

DME and Medical Supply Participating Provider Responsibilities

- Verify primary payer coverage and eligibility prior to delivery of products.
- Acquire physician orders whenever required by regulation or local, state, or federal law, and/or third-party reimbursement.
- Exhaust all other payment sources prior to billing Anthem.
- Deliver requested products in a timely manner.

Note: It is the responsibility of the participating provider to determine whether Medicare covers the item or service being billed. If the service or item is covered or if the participating provider does not know if the service or item is covered, the participating provider must first submit a claim to Medicare, as Anthem is always the payer of last resort. If the item is normally covered by Medicare, but the participating provider has prior information that Medicare will not reimburse due to same or similar, duplicate, or excessive deliveries, the information should be communicated to the Anthem care manager prior to delivery.

Home Delivered Meal Provider Responsibilities

- Provide nutritionally balanced meals that meet 1/3 of the daily Recommended Dietary Allowance (RDA).
- Serve hot meals, with no more than two preapproved cold meals served per week.
- Make meal deliveries each weekday except for agreed-upon holidays, or as specified in contract
- Monitor those members receiving home-delivered meals. Meal deliverers must have direct, face-to-face contact with the member at the time of delivery, except if the meal provider dropships frozen meals
- Communicate with the case manager or caseworker about changes in member's needs or when the member suspends services due to hospitalization or an extended visit away from home
- Serve a variety of appealing foods and make approved menus available to member. Members must have the opportunity to offer input on meal planning and meal service
- Deliver meals within the time frame stated to member, and explain the agency's policies and procedures to member
- Establish emergency procedures for circumstances such as inclement weather or vehicular breakdown and ensure members are notified when meals can't be delivered or will be late
- Ensure delivery people are appropriately trained and supervised
- Prepare food according to principles of nutritional health and safety

Claims Submission

Anthem providers are required to submit claims for services reimbursed from Anthem on a fee-for-service basis. It is essential that claims be submitted in a timely and accurate manner.

Payment for services rendered is subject to verification that the member was enrolled in Anthem at the time the service was provided, as well as the provider's compliance with Anthem care management and prior authorization policies at the time of service.

Providers should verify member eligibility at the time of service to ensure the member is enrolled in Anthem. Failure to do so may affect claim payment. Additionally, note that members may retroactively lose their eligibility with Anthem after the date of service. Therefore, verification of eligibility is not a guarantee of payment. Claims submitted for services rendered without proper authorization (as applicable) will be denied for failure to obtain authorization and no payment will be made.

Billing Time Frame Requirements

Providers are encouraged to file claims as soon as possible and no later than 120 days from the date on which covered services were provided:

- For claims subject to Coordination of Benefits (COB) rules, providers must submit claims to Anthem or its delegate, as secondary payer, within 120 days of Anthem provider's receipt of payment and/or Explanation of Benefits (EOB) from the primary payer.

Claims not submitted within these time frames may be denied for untimely submission. Claims denied for untimely submission will only be paid if and when the provider can demonstrate that the late submission was the result of an occurrence outside the provider's control, and that the provider has otherwise demonstrated a pattern of timely submission.

Clean Claims

A *clean claim* is defined as a claim that has no defect, impropriety, or lack of substantiating documentation. Such documentation includes the information necessary to meet the requirements for encounter data, as well as a completed *UB-04* or *CMS-1500* form, their respective successor forms, or alternative electronic equivalents for covered services. Note that electronic equivalents must conform to all *HIPAA Administrative Simplification Act* requirements for electronic transactions. Additionally, these forms must comply with standard CMS coding guidelines, and/or other government program requirements where applicable. Clean claims require no further documentation, information, or alteration in order to be processed and paid in a timely manner by Anthem.

Prior to being processed for payment, all claims are reviewed for completeness and correctness of the required data. The following information must be included in a claim for it to be considered clean:

Required data	*UB-04*	*CMS-1500*
Patient Name	✓	✓
Patient Date of Birth	✓	✓
Patient Sex	✓	✓
Subscriber Name & Address	✓	✓
Anthem Member ID Number	✓	✓
Coordination of Benefits (COB)/other insured's information	✓	✓
Date(s) of Service	✓	✓
ICD-10Diagnosis Code(s) including 4th & 5th Digit if Required	✓	✓
CPT-4 Procedure Code(s)	✓	✓
HCPCS Code(s)	✓	✓
Service Code Modifier (if applicable)	✓	✓
Place of Service	N/A	✓
Service Units	✓	✓
Charges per Service and Total Charges	✓	✓
Provider Name	N/A	✓

Required data	*UB-04*	*CMS-1500*
Provider Address / Phone Number	N/A	✓
National Provider Identifier – NPI	✓	✓
Provider Tax ID Number	✓	✓
Anthem Provider ID Number	✓	✓
Nursing Home / Facility Name and Address	✓	N/A
Type of Bill	✓	N/A
Admission Date and Type	✓	N/A
Condition Code(s)	✓	N/A
Patient Discharge Status Code	✓	N/A
Occurrence Code(s) and Date(s)	✓	N/A
Value Code(s)	✓	N/A
Revenue Code(s) and Corresponding CPT/HCPCS Code(s) (outpatient services)	✓	N/A
Principal, Admitting, and Other ICD-9 Diagnosis Code(s)	✓	N/A
Present on Admission (POA) Indicator (if applicable)	✓	N/A
Attending Physician Name and NPI	✓	N/A
Anthem Authorization Number	✓	N/A

The UB-04 form should be used by facilities and billing on behalf of employed providers.
CMS 1500 forms and UB-04s can be used to bill fee-for-service encounters.

Preferred Claim Submission Method

Anthem strongly encourages providers to submit claims electronically.

Electronic Claims Submission

Availity is a partner for managing Electronic Data Interchange (EDI) transactions for the Anthem Managed Long-Term Care (MLTC) Plan. **The payer ID number is 45302.**

Electronic Data Interchange (EDI) allows for a faster, more efficient, and cost-effective way for providers to do business. For the MLTC plan, use Availity for the following EDI transactions:

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

Availity's EDI submission options:

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

EDI Response Reports

Claims submitted electronically will return response reports that may contain rejections. If using a Clearinghouse or Billing Vendor, please work with them to ensure you are receiving all reports. It's important to review rejections as they will not continue through the process and require correction and resubmission. For questions on electronic response reports, contact your Clearinghouse or Billing Vendor or Availity at **800-AVAILITY (800-282-4548).**

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

PaySpan Health gives providers the option to receive electronic payment directly to their bank accounts.

There are immediate benefits to signing up for PaySpan Health:

- **Improve cash flow:** electronic payments can mean faster payments, leading to improvements in cash flow.
- **Maintain control over bank accounts:** allows **total** control over the destination of claim payment funds. Multiple practices and accounts are supported.
- **Match payments to EOP:** Associate electronic payments quickly and easily to an advice/voucher.

Registering Your Practice

Signing up for PaySpan Health is simple, secure, and will only take 5 to 10 minutes to complete. To enroll, you must register as a user on the PaySpan Health website.

Using your web browser, go to **http://www.payspanhealth.com.** Enter your unique registration code and PIN, provided **in a separate correspondence that will be sent via USPS to each provider.** Have your bank routing and account information found on a check, not a deposit slip, available.

A step-by-step guide for registration is available online.

Paper Claims Submission

Paper claims may be submitted in lieu of electronic claims and may be used prior to completion of electronic billing arrangements in order to comply with timely filing requirements. Company invoices, statements, or spreadsheets will not be accepted. Paper claims should be completed in their entirety, including but not limited to the following data elements:

All *CMS-1500* claims must include:

- Member name
- Payer-specific member ID number of 11 digits: a group of 9 digits followed by a group of 2 digits (typically “00”)
- Date of birth
- Members insurance carrier name
- Provider name, Tax ID number, and NPI number
- Date of service that falls between the effective and expiration dates printed on the authorization
- Valid place of service code
- Service code such as HCPCS/CPT® (the billed service code **must** match the code that is listed in the authorization)
- Number of units
- Co-insurance claims must include a copy of the primary insurer EOB
- Valid diagnosis code
- Valid place of service

All *UB-04* claims must include:

- Member name
- Payer-specific member ID number of 11 digits: a group of 9 digits followed by a group of 2 digits (typically “00”)
- Date of birth
- Members insurance carrier name
- Provider name, Tax ID Number, and NPI number
- Date of service that falls between the effective and expiration dates printed on the authorization.
- Service code such as HCPCS/CPT (billed service code **must** match the code that is listed in the authorization)
- Number of units
- Co-insurance claims must include a copy of the primary insurer EOB
- Valid bill type
- Valid revenue code
- Valid value code(s) and occurrence code(s)
- Applicable admit dates

Please mail claims to:

Anthem Blue Cross and Blue Shield
P.O. Box 211493
Eagan, MN 55121

Claims Payments

Anthem, or its delegate, will pay claims within 30 days of receipt, so long as the claim is clean and submitted in an electronic format. Clean claims submitted by other means, such as paper, will be paid within 45 days of receipt.

Claims Inquiries

Providers may call Anthem's Provider Service Line at **929-946-6500** to inquire on the status of claims.

Submitting a Corrected Claim

Corrected claims should be submitted when data has changed from the original submission of the claim. As an example, a corrected claim should be submitted if any of the following data changes: service dates, procedure codes, units, charges, diagnosis codes.

Corrected claims should not be submitted if a claim was denied for lack of authorization or if there was a retroactive rate change, rather a claim dispute should be filed.

When submitting a corrected claim to Anthem please ensure that the following data elements are present:

- *CMS-1500* form, use Item Number 22
  - Resubmission code
    - 7 Replacement of prior claim (used to correct a previously submitted bill)
    - 8 Void/cancel of prior claim (used to indicate this bill is an exact duplicate of an incorrect bill previously submitted)
  - Original Ref. No.
    - Anthem Claim ID of the claim that is being corrected
- *UB-04* form
    - Field 4 Bill Type
      - 4th Digit requirement
- 7 Replacement of Prior Claim (used to correct a previously submitted bill)
- 8 Void/Cancel of a Prior (used to indicate this bill is an exact duplicate of an incorrect bill previously submitted)
  - Field 64 Document Control Number
    - Anthem claim ID of the claim that is being corrected

Please keep in mind that Anthem will adjust the original claim in its entirety based on the claim ID presented on the claim form.

Common errors to avoid:

- **Error**: Underpayment of corrected claims
  - Original claim ID is processed for 5 lines, 4 are paid, line 5 unpaid due to invalid charges.
  - New corrected claim submitted only for line 5.
  - Anthem will reverse the entire original claim and process the new claim.
    - Anthem processes new claim and pays line 5.
    - Provider is now underpaid as lines 1-4 were reversed and replaced by line 5.
- **Solution**: submit the corrected claim with all 5 lines, with line 5 now having charges.
- **Error**: Claim denied for lack of authorization
  - Original claim denied
  - New corrected claim has no data element changes
    - Anthem may reverse the entire original claim and deny for the same reason
    - Deny for invalid corrected claim as no data has been changed
- **Solution**: Submit a claim dispute (refer to **Requests for Review and Reconsideration of a Claim Section**)

Authorizations issued with a weekly frequency

Anthem may issue authorizations with a weekly frequency, where a week is defined as starting on Sunday and ending on Saturday. Units authorized for a single week only apply for that week, unused units cannot be applied to prior weeks or banked for use in future weeks.

Examples of services which may receive an authorization with a weekly frequency are CDPAS, Meals on Wheels, Social Day Care, and Personal Care.

To avoid payment issues please ensure that services billed with an approved weekly frequency do not exceed the approved units for that week. The processing week, with or without updates to authorizations are calculated as Sunday to Saturday. Anthem will conduct post payment reviews to ensure weekly units are not exceeded. Please refer to the section titled **Overpayments and Overpayment Recoveries** for detail on the process Anthem will use when an overutilization of an approval is identified.

Requests for Review and Reconsideration of a Claim

Please note that the process described here does not apply to utilization management determinations concerning medical necessity.

Providers dissatisfied with a claim determination must submit a written request for review and reconsideration (including supporting documentation) within 60 calendar days from the date on the provider's Explanation of Payment (EOP). The EOP details the adjudication of claims, describing the amounts paid or denied and indicating the determinations made on each claim.

All written requests for review and reconsideration must include a copy of the EOP, the claim, supporting documentation, and a written statement explaining why you disagree with Anthem's determination. The following should also be included:

- Provider's name, address, and telephone number
- Member name and Anthem identification number
- Date(s) of service
- Anthem claim number
- A copy of the original claim if applicable
- A copy of the EOP from another insurer or carrier along with supporting records to demonstrate medical necessity
- Contract rate sheet to support payment rate or fee schedule
- Evidence of eligibility verification for the date of service
- Evidence of timely filing – *Insurance Carrier Rejection Report* (Please note: Anthem does not accept copies of certified mail, overnight mail receipts, or documentation from internal billing practice software as proof of timely filing.)

The written request must be sent to:

Anthem Blue Cross and Blue Shield
Appeals and Grievances
1985 Marcus Avenue, Suite 150
Lake Success, NY 11042

Anthem will investigate all written requests for review and reconsideration and issue a written explanation as to why the claim has been reprocessed or the initial denial has been upheld. The explanation will be issued within 45 days from the date of receipt of the provider's request for review and reconsideration.

Anthem will not review or reconsider claim determinations that are not appealed according to the procedures set forth above.

Coordination of Benefits (COB)

Anthem providers are expected to cooperate with Anthem or its delegates in evaluating possible subrogation claims, and to properly coordinate benefits in accordance with applicable laws and coordination of benefit guidelines. If Anthem is not the primary payer, providers are expected to bill the payer(s) with primary liability prior to submitting bills for the same service to Anthem or its delegates. Providers must also provide Anthem or its delegates with relevant information collected from member regarding

coordination of benefits. If Anthem is not the member's primary payer, provider compensation will be no more than the difference between the amount paid by the primary payer(s) and the applicable rate under the *Provider Agreement*.

Payment in Full/Member Held Harmless

Anthem providers agree to look solely to Anthem for payment of covered services rendered and to accept payment from Anthem as payment in full. Under no circumstances should a provider bill, charge, or seek compensation of any sort from member or persons acting on member behalf for covered services.

Although providers may bill members if a service is not covered and is provided on a fee-for-service basis, members must first be advised in writing that the service is a non-covered service, and that the member is liable for the non-covered service. Again, such consent must be acquired ***prior*** to providing the service.

Overpayments and Overpayment Recoveries

Anthem periodically reviews payments made to providers to ensure accuracy. Such reviews are pursuant to the terms of the provider contract and are part of Anthem utilization review and fraud control programs. If Anthem identifies instances of overpayment, it will provide a notice to the provider of overpayment, as well as methods for recoupment of the overpayment consistent with Section 3224b of the New York State Insurance Law.

Additionally, Anthem will pursue overpayment recovery efforts if:

- A reasonable belief of fraud, intentional misconduct, or abusive billing exists, or
- Required by a state or federal government program.

Providers may request that Anthem offset the overpaid amount against future payments or submit a refund check made payable to Anthem within 30 calendar days of the date of overpayment notice. Failure to refund the overpayment within 30 days of the date of the overpayment notice will result in the overpayment balance being deducted from the next claim payment. Providers should also include a statement in writing regarding the purpose of the refund check to ensure proper recording and timely processing of the refund.

All communication related to overpayment and any refund checks should be directed to:

Anthem Blue Cross and Blue Shield
Finance Department
1985 Marcus Avenue, Suite 150
Lake Success, NY 11042

Compliance

Provider Compliance Training

Anthem requires providers to conduct compliance and *HIPAA* privacy and security training to all employees at hire and annually thereafter. The training must include at a minimum:

***HIPAA* Privacy and Security Training**

The training must summarize privacy and security requirements in accordance with the federal standards established pursuant to *HIPAA*, and relevant state requirements. Training should include, but is not limited to, discussion of:

- Proper uses and disclosures of PHI
- Member rights
- Privacy and security safeguards

Fraud, Waste and Abuse (FWA) Training

This training must include, but is not limited to, discussion of:

- Laws and regulations related to fraud, waste and abuse (*False Claims Act*, Anti-Kickback statute, *Deficit Reduction Act)*
- Obligations of the provider, including provider employees and provider sub-contractors and their employees, to have appropriate policies and procedures to address fraud, waste, and abuse
- The process for reporting suspected fraud, waste and abuse
- Protections for employees and subcontractors who report suspected fraud, waste and abuse, and
- Types of fraud, waste and abuse that can occur

Code of Conduct

Anthem is dedicated to adhering to the highest ethical business standards and legal compliance. The practice of ethical business judgment, ethical personal behavior, as well as compliance with applicable laws, policies, and procedures are expected of all Anthem employees. The Code of Conduct details the fundamental principles, values, and procedures to address misconduct. It is intended to deter wrongdoing and promote:

- Honest and ethical conduct within the workplace and with our members
- Compliance with all applicable governmental laws, rules and regulations
- Prompt internal reporting of violations and compliance concerns, and
- Prompt response to violations and compliance concerns

Fraud, Waste, and Abuse (FWA)

Our goal is to make sure our healthcare program works well and that we catch any problems like fraud, waste, or abuse. 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.

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

Every Member identification card lists the following:

- Effective date of membership
- Member date of birth
- Subscriber number (identification number)
- Vision service plan telephone number and dental service plan telephone number
- Member Services and Nurse Helplines telephone numbers

Presentation of a Member identification (ID) card does not guarantee eligibility; Providers should verify a Member's status by inquiring online or via telephone. Online support is available for Provider inquiries on the website, and telephonic verification may be obtained through the automated Provider Inquiry Line at **929-946-6500**.

Providers should encourage Members to protect their ID cards as they would a credit card, to carry their health benefits card at all times, and report any lost or stolen cards to the company as soon as possible. Understanding the various opportunities for fraud and working with Members to protect their health benefit ID card can help prevent fraudulent activities. Providers should instruct their patients who have lost their ID card to inspect their explanation of benefits (EOB) for any errors and then contact Member Services if something is incorrect.

Reporting Fraud, Waste and Abuse

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

You can report your concerns by:

- Visiting our fighthealthcarefraud.com education site; at the top of the page, select **Report it** and complete the *Report Waste, Fraud and Abuse* form.
- Calling Health Care Networks if you are a contracted provider.
- Calling Customer Service.
- Calling our 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.

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

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Overutilization
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling — when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding — when a Provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a provider (for example, a doctor, dentist, counselor, medical supply company), 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 (for example, doctor, dentist, therapist, pharmacist)

- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

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

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

Investigation Process

Our Special Investigations Unit (SIU) reviews all reports of Provider or Member fraud, waste and abuse for all services. If appropriate, allegations and the investigative findings are reported to all appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with Provider fraud, waste or abuse, which may include, but is not limited to:
- *Written warning and/or education*: We send 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 to previously submitted claims and/or to substantiate allegations.
- *Prepayment Review*: A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.
- *Recoveries*: We recover overpayments directly from the Provider. Failure of the Provider to return the overpayment may result in reduced payment 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 account. Contact Availity Client Services at 800-AVAILITY (282-4548) for more information.

About Prepayment Review

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

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

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

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

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

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

Acting on Investigative Findings

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

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

Failure to comply with program policy or procedures, or any violation of the contract, may result in termination from our plan.

If a Member appears to have committed fraud, waste or abuse or has failed to correct issues, the Member may be involuntarily dis-enrolled from our health care plan, with state approval.

Relevant Legislation

False Claims Act

We are committed to complying with all applicable federal and state laws, including the federal False Claims Act (FCA). The FCA is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the FCA, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages or loss to the government, plus civil penalties of $5,500 to $11,000 per false claim.
The FCA also contains Qui Tam or "whistleblower" provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government, or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under Qui Tam provisions in the FCA and may be entitled to a percentage of the funds recovered by the government.

HIPAA

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

Our company strives to ensure both Anthem and contracted participating Providers conduct business in a manner that safeguards Member information in accordance with the privacy regulations enacted pursuant to *HIPAA*. Contracted Providers shall have the following procedures implemented to demonstrate compliance with the *HIPAA* privacy regulations:

- Our company recognizes its responsibility under *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 us; however, privacy regulations allow the transfer or sharing of Member information. Our company may request information to conduct business and make decisions about care, such as a Member's medical record, authorization determinations or payment appeal resolutions. Such requests are considered part of the *HIPAA* definition of treatment, payment or health care operations.
- Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need Member information to perform their jobs. When faxing information to us, verify the receiving fax number is correct, notify the appropriate staff at our company and verify the fax was received.
- Internet email (unless encrypted and/or transferred by another secure service) should not be used to transfer files containing Member information, 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, P.O. Box or department at our company.
- Our company voice mail system is secure and password protected. When leaving messages for any of our associates, leave only the minimum amount of Member information required to accomplish the intended purpose.
- When contacting us, please be prepared to verify the Provider's name, address and tax identification number (TIN) or Member's Provider number.

Employee Education about the False Claims Act

As a requirement of the Deficit Reduction Act of 2005, contracted Providers who receive Medicaid payments of at least 5 million dollars (cumulative from all sources), must comply with the following:

- Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the network Provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).
- Include as part of such written policies detailed provisions regarding policies and procedures for detecting and preventing fraud, abuse and waste. Include in any employee handbook a specific discussion of the laws described in Section 1902(a) (68) (A), the rights of employees to be protected as whistleblowers, and policies and procedures for detecting and preventing fraud, abuse and waste.

Delegated Entities

Anthem compliance responsibilities extend to entities that, by written contract, perform functions or services on behalf of Anthem. While certain activities may be delegated, Anthem is ultimately responsible and accountable to the federal and state agencies for all services performed by its delegated entities. It is the responsibility of Anthem to monitor and evaluate the performance of the delegated functions to ensure compliance with regulatory requirements, contractual obligations, accreditation standards, and Anthem policies and procedures.

Anthem may require a corrective action plan or quality improvement plan if the delegated entity's performance is unsatisfactory. The delegated entity must cooperate with Anthem and work diligently and continuously to implement any corrective action plan or quality improvement plan required by Anthem to Anthem's satisfaction.

Anthem requires delegated entities to have at a minimum:

- Compliance plan/Code of Conduct
- *HIPAA* privacy and security training
- Compliance/FWA training
- Disaster recovery and business continuity

Appeals and Complaints

Addressing Member Problems and Concerns

Anthem is focused on addressing member problems as quickly as possible. Depending on the nature of the issue, either the complaint process or appeal process may be more appropriate.

Filing of a complaint or appeal by member will result in no change in their service or treatment by either Anthem staff or health care providers. Anthem will also continue to safeguard member privacy and provide any help necessary to complete the filing process. This includes providing member with interpreter services or assistance if they have vision and/or hearing problems. Providers may assist members with a complaint or appeal, as may member friends or relatives.

What is a Complaint?

A complaint is any communication by a member or provider to Anthem of dissatisfaction about the care and treatment members receive from our staff or providers of covered services. For instance, dissatisfaction with behavior by a staff member or with the quality of a service received may be expressed with a complaint. Complaints will be reviewed by the Grievance Department, and if the complaint pertains to clinical matters, personnel reviewing the complaint will include a licensed, certified, or registered health care professional.

Complaint Process

A complaint may be filed, in person, verbally or in writing. Upon being received by Anthem, the complaint will first be recorded, and then the appropriate staff will oversee its review. Anthem will also send a notification letter to the member indicating his complaint is received, as well as a description of the review process. The complaint will be reviewed, and a written answer provided within one of two time frames:

- If a delay would significantly increase the risk to a member's health, Anthem will provide a complaint decision within 48 hours of all information being received; no longer than seven days after the receipt of the complaint
- For all other types of complaint, Anthem will notify member of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint. The review period can be increased up to 14 days if so requested or if Anthem needs more information and the delay is in the member's interest

Anthem response will include a description of findings and the complaint decision.

State and Federal Complaint Options

A member, the member's Representative, or the provider may file a complaint at any time. To pursue complaints with the NYSDOH, call **866-712-7197** or email at mltctac@health.ny.gov.

Appealing a Complaint Decision

If a member is not satisfied with Anthem, due to a decision concerning a complaint, a second review of the issue may be initiated by filing a complaint appeal. This must be filed in writing and within 60 business days of receipt of our initial decision about the complaint. Once Anthem receives an appeal, a written acknowledgement is sent containing information regarding the name, address, and telephone number of the individual Anthem has designated to respond to the appeal. All complaint appeals will be conducted by appropriate professionals, including health care professionals for complaints involving clinical matters. None of the individuals reviewing the appeal are permitted to have been involved in the initial decision.

Time frames for Handling Complaint Appeals

For standard appeals, Anthem will make the appeal decision within 30 business days of receiving all information necessary for the decision. If a delay in making the decision would significantly increase the risk to a member health, Anthem will use the expedited complaint appeal process. For expedited complaint appeals, Anthem will make the appeal decision within two business days of

receipt of necessary information. For both standard and expedited complaint appeals, Anthem will provide members with written notice of the decision. The notice will include detailed reasons for the decision and, in cases involving clinical matters, the clinical rationale for the decision.

After a determination is made on the complaint appeal, there are no further appeals.

Actions and Appeal of Actions

What is an Action?

Any of the following constitutes an action when performed by Anthem:
- A denial or limited authorization of a requested service
- A restriction, reduction, suspension, or termination of a previously covered service
- Denial of payment for services, either in whole or in part
- Failure to provide timely services
- Determination that a requested service is not a covered benefit
- Failure to make grievance, appeal, and grievance appeal determinations or notifications within the required time frames
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities

An action is subject to appeal. (See **How do I File an Action Appeal?** below for more information.)

Timing of Notice of Action/Explanation of Payment (EOP)

If Anthem decides to deny or limit requested services or decides not to pay for all or part of a covered service, a notice will be sent when the decision is made. A letter will be sent to the member at least 10 days prior to the restriction, reduction, suspension, or termination of authorized services.

Contents of Notice of Action/Explanation of Payment (EOP)

Notices Anthem sends regarding an action will:
- Explain the action taken or intended to be taken
- Cite the reasons for the action, including the clinical rationale, medical necessity criteria, and any processes, strategies, or evidentiary standards used, if any, and the right of the enrollee to receive, upon request and free of charge, access to and copies of all documents, records, and other information relevant to the adverse benefit determination
- Describe the right to file an appeal with Anthem (including whether a right to the State's external appeal process exists)
- Describe how to file an internal appeal and the circumstances under which an expedited review of the internal appeal can be requested
- Describe the availability of the clinical review criteria relied upon in making the decision (if the action involves issues of medical necessity, or if it involves a treatment or service that is experimental or investigational)
- Describe the information, if any, which must be provided by the member and/or the provider in order for us to render a decision on appeal

The notice will also contain information regarding the right to a State Fair Hearing after exhausting Anthem one level of appeal:
- It will explain the difference between an internal appeal and a Fair Hearing
- It will state that an internal appeal must be filed prior to requesting a Fair Hearing
- It will explain how to request a Fair Hearing
- It will state that if Anthem is restricting, reducing, suspending, or terminating an authorized service and the member wants services to continue while the appeal is decided, an internal appeal must be requested within 10 days of the date on the notice or the intended effective date of the proposed action, whichever is later
- It will explain that Anthem will not act in any manner as to restrict the right to a Fair Hearing or to influence a member decision to pursue a Fair Hearing

How do I file an Action Appeal?

If members don't agree with Anthem initial Adverse Determination, a plan appeal may be filed. Such a filing triggers a review of our initial ruling in order to determine if it is correct. The member, member's representative or providers have 60 calendar days from the date of the Initial Adverse Determination to request a plan appeal.

An appeal may be filed in person, verbally or in writing. If verbally, Anthem provides the member with a summary of the appeal in writing, either as part of the acknowledgement or separately. The date of the oral request for both standard and expedited appeals is treated as the date of the appeal. An enrollee's written consent is required for representatives to request plan appeal, grievance or fair hearing on their behalf. Providers may request appeal, grievance or fair hearing, but may not request Aid Continuing.

Note: New York requires that Member exhaust the Plan's internal appeal process before a member, or anyone on behalf of a member, may request a State Fair Hearing or an External Appeal.

How do I Contact Anthem to file an Appeal?

Anthem can be reached at **855-800-4683** (TTY/Services, call **711**), Fax **718-368-6267,** email MLTCgrievanceandappeals@Anthem.com or by mail:

Anthem Blue Cross and Blue Shield
Appeals and Grievances
1985 Marcus Avenue, Suite 150
Lake Success, NY 11042

Anthem will record the member appeal upon receiving it, and then appropriate staff will oversee its review. A notification letter will be sent indicating the appeal is received and describing how it will be processed, and then knowledgeable clinical staff who were not involved in the initial decision or action that is being appealed will review the appeal.

How Long Will It Take Anthem to Decide an Action Appeal?

Standard Appeal Process

Anthem will process appeals on the standard time frame, sending a written decision as quickly as the member's health condition requires, and in any event no later than 30 days from the day Anthem receives the appeal. (The review period can be increased up to 14 days if so requested by the member, or if Anthem needs more information and the delay is in the member's interest.) During Anthem review, members will have a chance to present their case in person and in writing. They will also have the chance to look at any records that are part of the appeal review.

Anthem will then send member a notice regarding the appeal decision. It will identify both the decision made and the date of the decision.

If Anthem reverses a decision to deny, limit, reduce, suspend, or terminate requested services, and services were not furnished while a member's appeal was pending, Anthem will provide the member with the disputed services as quickly as her health condition requires.

If the member or a provider acting on the member's behalf feels that taking the time for a standard appeal could result in serious risk to the member health or life, an expedited review of the appeal of the action may be requested. If the expedited appeal request is approved, a decision will be made within 72 hours. The review period can be increased up to 14 days if the member requests an extension, or if Anthem needs more information and the delay is in the member's interest.

If Anthem does not agree with a request to expedite an appeal, Anthem will make its best effort to notify the member of the denial to expedite and the appeal will be handled as a standard appeal. A written notice of such decision will be sent within two days of receiving the request.

If a standard action appeal is filed with Anthem and the original decision is upheld, the Member will receive a Final Adverse Determination which provides the member with the rights to a Fair Hearing and External Appeal rights.

Expedited Appeal Process

If the member, the member's representative or the provider feels the time required for a standard appeal could result in serious risk to the life or health of the member, an expedited review of the appeal may be requested. Anthem will issue a decision within 72 hours. The review period can be increased up to 14 days if the member requests an extension or if Anthem needs more information and the delay is in the member's interest.

Member Options If Anthem Denies an Appeal

If an appeal decision is not totally in the member favor, the member will receive a Final Adverse Determination notice explaining the rights to request a Medicaid Fair Hearing from New York State and how to obtain it, as well as information regarding who can appear at the Fair Hearing on the member's behalf. Additionally, for some appeals, member will receive information regarding the right to request to continue receiving while a Hearing is pending, as well as instructions on how to make the request.

A Fair Hearing must be requested within 120 calendar days, from the date of the Final Adverse Determination. If Anthem denies the appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an external appeal of our decision.

State Fair Hearings

A Fair Hearing may be requested from New York State if the member received a Final Adverse Determination or the time for the Plan to decide the internal appeal has expired including any extensions. Also, if there is no response to the internal appeal, the member may request a Fair Hearing. A Fair Hearing can overrule Anthem final decision. A Fair Hearing must be requested within 120 calendar days of the date of the Final Adverse Determination notice. Members must exhaust Anthem internal appeal process before they can ask for a Fair Hearing.

The State Fair Hearing process allows a member's services to continue while the member is waiting for the case to be decided. If Anthem sends a member a notice about restricting, reducing, suspending, or terminating services the member may continue receiving services until the Fair Hearing is decided.

If the State Fair Hearing Officer reverses Anthem decision, we are required to ensure that the member receives the disputed services within 72 hours.

Although the member may request services continue while waiting for the Fair Hearing decision, if the Fair Hearing is not decided in the member's favor, the member may be responsible for paying for the services that were the subject of the Fair Hearing.

File a State Fair Hearing by contacting the Office of Temporary and Disability Assistance:

Request a Fair Hearing online using the form:

https://otda.ny.gov/oah/FHReg.asp.

Mail a Printable Request Form

NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings
Managed Care Hearing Unit
P.O. Box 22023
Albany, New York 12201-2023

Fax Fair Hearing Request Form to: **518-473-6735**

Request by Telephone

800-342-3334

TTY line: **711** (request that the operator call **877-502-6155**)

Request in Person

New York City

Office of Temporary and Disability Assistance
Office of Administrative Hearings
14 Boerum Place, 1st Floor
Brooklyn, New York 11201

For more information on how to request a Fair Hearing, please visit: **http://otda.ny.gov/hearings/request/**

State External Appeals

If an appeal is denied because Anthem determines the service is not medically necessary or is experimental/investigational, members may ask for an external appeal from New York State. The external appeal is decided by reviewers who do not work for either Anthem or New York State, but who are qualified and approved by New York State. Members do not have to pay for an external appeal.

When Anthem denies an appeal for lack of medical necessity or on the basis of the service being experimental/ investigational, Anthem will provide member with information about how to file an external appeal, as well as a filing form. If members want the external appeal, they must file the form with the New York State Department of Financial Services within four months from the date of the Final Adverse Determination notice.

The external appeal will be decided within 30 days the reviewer will then inform the member and Anthem of the final decision within two business days of the decision being made.

A faster decision may be received if the member's doctor indicates a delay will cause serious harm to the member's health. This is called an expedited external appeal. The external appeal reviewer will decide such an appeal in 72 hours. The reviewer will then inform the member and Anthem of the decision immediately by either phone or fax. Later, a letter will also be sent that informs the member of the decision.

Member may ask for both a Fair Hearing and an external appeal. If they ask for a Fair Hearing and an external appeal, the decision of the Fair Hearing officer will supersede the external appeal.

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
    a. 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:

1. Individual or group practices;
2. Facilities;
3. Rental networks:
    a. That are part of Anthem's primary Network and include Anthem Members who reside in the rental network area.
    b. 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
4. Telemedicine.

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 (for example, 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 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 on 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 (for example, 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 (for example, 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 their judgment might otherwise be compromised. A committee member will also disclose if they have 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. In the event that 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 Plan programs or provider Networks on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Anthem will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities which are provided to the Members to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners and providers require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence. The CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Anthem will audit credentialing files annually to identify discriminatory practices, if any, in the selection of practitioners. In the event discriminatory practices are identified through an audit or through other means, Anthem will take appropriate action 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 used. To learn more about CAQH, visit their web site at CAQH.org.

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

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 Members. 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 or limitations
Medicare, Medicaid or FEHBP sanctions
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

Re-credentialing

The re-credentialing process incorporates re-verification and the identification of changes in the practitioner's or HDO's licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner's or HDO's professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Anthem credentialing standards ("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 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 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. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

Anthem Credentialing Program Standards

Eligibility Criteria

Health care practitioners:

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

1. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP;
2. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where they provide services to Members;
3. Possess a current, valid, and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if applicable to their specialty in which they 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
4. Meet the education, training and certification criteria as required by Anthem.

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

- 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.
- 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.
- 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.
- Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.

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

1. Previous board certification (as defined by one) of the following: ABMS, AOA, RCPSC, CFPC, 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;
2. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty; or
3. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty and a faculty appointment of assistant professor or higher at an academic medical center and teaching facility in Anthem's network and the applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.

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:

- 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), a 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.
- 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.

Criteria for Selecting Practitioners

New Applicants (Credentialing):
- Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions.
- Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote.
- Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies.
- No evidence of potential material omission(s) on application.
- Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Members.
- No current license action.
- No history of licensing board action in any state.
- No current federal sanction and no history of federal sanctions (per System for Award Management (SAM), OIG and OPM report nor on NPDB report).
- Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to their specialty in which they 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.
- Initial applicants who have no DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that they have applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:
    - It can be verified that this application is pending.
    - 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;
    - The applicant agrees to notify Anthem upon receipt of the required DEA/CDS registration.
    - Anthem will verify the appropriate DEA/CDS registration via standard sources.
    - The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90-calendar day timeframe will result in termination from the Network.

Initial 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 <u>all</u> the following criteria are met:

1. It can be verified that the applicant's application is pending; and
2. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
3. The applicant agrees to notify Anthem upon receipt of the required DEA registration; and
4. Anthem will verify the appropriate DEA/CDS registration via standard sources; and
5. 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:

1. controlled substances are not prescribed within their scope of practice; or in their professional judgement, the patients receiving their care do not require controlled substances and
2. they 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
3. DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than those aforementioned.
    a. 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.
    b. No history of or current use of illegal drugs or history of or current substance use disorder.
    c. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
    d. 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.
    e. 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.
    f. A minimum of the past 10 years of malpractice claims history is reviewed.
    g. 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.
    h. No involuntary terminations from an HMO or PPO.
    i. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
        i. Investment or business interest in ancillary services, equipment or supplies;
        ii. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
        iii. Voluntary surrender of state license related to relocation or nonuse of said license;
    j. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    k. 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);
    l. 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.
    m. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    n. 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:
    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:
    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 or doctoral degrees in divinity, masters 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:
            a. 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:
            a. 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 (for example, 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.
    c. 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.

5. Clinical Psychologists:
    a. Valid state clinical psychologist license.
    b. Doctoral degree in clinical or counseling, psychology or other applicable field of study.
    c. 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.

6. 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.

7. 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 (for example, psychiatrist, clinical psychologist, licensed clinical social worker).
    c. Practitioner must possess a valid psychoanalysis state license:
        i. Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
        ii. Meet examination requirements for licensure as determined by the licensing state.

8. 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 either via verification of the licensure status from the state licensing agency provided that that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional education and training If the licensing agency or certification board does not verify highest level of education, the education will be primary source verified in accordance with policy.
    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. This certification must be active and primary source verified.

If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Anthem is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review.

f. If the NP 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 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.
h. Upon completion of the credentialing process, the NP may be listed in Anthem's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
i. NPs will be clearly identified:
    i. On the credentialing file;
    ii. At presentation to the CC; and
    iii. Upon notification to network services and to the provider database.

9. 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 either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.
    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 and primary source verified. If the state licensing board primary source verifies one) of these certifications as a requirement for licensure, additional verification by Anthem is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic CC.
    f. 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 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.

g. 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.
h. Upon completion of the credentialing process, the CNM may be listed in Anthem's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
i. CNMs will be clearly identified:
    i. On the credentialing file;
    ii. At presentation to the CC; and
    iii. Upon notification to network services and to the provider database.

10. 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 and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Anthem is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to 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 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.
    h. Upon completion of the credentialing process, the PA may be listed in Anthem provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
    i. PAs will be clearly identified:
        i. On the credentialing file;
        ii. At presentation to the CC; and
        iii. Upon notification to network services and to the provider database.

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 and no new (since prior credentialing review) history of federal sanctions (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 last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
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.

A. 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.

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.
- 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.
- 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.

Additional Participation Criteria for HDO by Provider Type:

HDO Type and Anthem Approved Accrediting Agent(s)

Facility Type (Medical Care)	Acceptable Accrediting Agencies
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

On-Site Reviews

Anthem sometimes conducts on-site reviews to evaluate the suitability of a provider's service site. These reviews are performed for all providers operating in sites other than member's homes, including, Social Adult Day Care Centers and for Consumer Directed Personal Assistance Providers.

Delegated Credentialing for Vision and Dental Services

Anthem delegates credentialing for dental and vision providers to entities contracted for the provision and management of these services. As part of the contracting process, such entities submit copies of their policies and procedures, a description of their credentialing and re-credentialing criteria, and other relevant processes to Anthem Credentialing Committee for approval. Anthem also requires these entities to certify that all providers participating in their respective networks meet Anthem credentialing requirements.

Demographic Update

It's critical that the information in our provider files is accurate, current, and complete. To ensure the plan and our members have the most accurate information about your practice, please complete the Provider File Change Form whenever your practice information is updated or changed. (Please refer to ***Exhibit B***).

Provider Termination and Obligations upon Termination

If Anthem decides not to renew a provider contract, the provider receives written notice of the decision 60 days prior to the date of termination. Anthem may also terminate the contract for any reason if 90 days' written notice is given. Such written notice will include the following:

- The reason(s) for the termination, and
- Except in cases of non-renewal, notice that the provider has the right to request a hearing or review in accordance with applicable state law (if the provider is an individual physician or other individual provider licensed under Title 8 of the New York Education Law).

Independent of the re-credentialing process, Anthem may suspend or terminate a provider's participation in the network for cause at any time. Participation will be terminated immediately, and the provider denied the right to a review if:

- Anthem determines that the provider has engaged in fraud
- The provider becomes uninsured or uninsurable with regard to professional liability coverage
- The provider dies
- The provider becomes disabled for a period of time exceeding three months such that the provider is unable, in the opinion of a physician selected by Anthem, to fulfill their contractual obligations with Anthem, or
- The provider takes any public or private action clearly contrary to the best interests of Anthem

Once providers are notified of contract termination, they may submit a request for an appeal as outlined in the letter of rejection/termination sent by Anthem. Such a request must be received within 30 days of the date of the rejection/termination letter.

Please send appeal requests sent to:

Anthem Blue Cross and Blue Shield
Credentialing Appeals Committee
1985 Marcus Avenue, Suite 150
Lake Success, NY 11042

When a provider initiates termination of the participation agreement with Anthem, any payments accrued to the provider are payable by Anthem prior to termination. Additionally, the provider has the following obligations:

- Providers won't seek compensation from member for covered services delivered prior to the effective date of termination
- Providers will continue to permit Anthem access to member records, and to provide Anthem with copies of all records of services rendered to members on or prior to the effective date of termination
- Providers will cooperate fully with Anthem in the transfer of members to other providers and ensure that provision for medically necessary services is in place prior to suspension of the provider's services
- If necessary, providers are obligated to continue care for a member for up to 180 days following notice of termination or until such time as Anthem makes alternate arrangements for member, whichever first occurs

Please note that termination procedures are subject to the provisions of the provider agreement. If there is a conflict between the provisions in the provider manual and the provider's agreement, the terms of the provider agreement will supersede those of the manual.

Provider Network Monitoring & Evaluation

Provider Network Monitoring

Anthem regularly conducts reviews of its provider network to ensure it supplies members with meaningful choice, timely access to providers, and that it accommodates special member needs. Network development is guided by these reviews, incorporating Anthem ongoing assessment of any service issues and Anthem performance in resolving these issues.

Provider Performance Monitoring

Anthem, the Department of Health (DOH), and their designees have the right to monitor participating providers' performance of contracted services. This includes, but is not limited to, the quality, appropriateness, degree of access to, and the timeliness of such services. The monitoring may take place during normal business hours, or any other time a provider's contracted functions are being conducted, and may be achieved through inspection or any other reasonable means.

Providers are required to cooperate with and reasonably assist Anthem, DOH, and their designees when this monitoring is being performed.

Providers are evaluated on the following criteria:

- Maintenance of credentialed status (after both credentialing and re-credentialing, and by ensuring timely re-credentialing)
- Compliance with not only contractual standards, but also the policies and procedures outlined in the provider manual and subsequent communications
- Accuracy of billing and the existence of any patterns of error, as determined through documentation of service provision, and
- Satisfactory performance of services, as indicated by:
    - Absence of provider-related member complaints or satisfactory redress of such complaints
    - Service provision within the established service time frame guidelines in the previous section
    - Timely and satisfactory implementation of any corrective action plan established in follow up to an identified issue, and
    - Clean results from audit or reviews conducted (for example, financial, quality review, and record keeping)

Documents collected and reviewed include, but are not limited to:

- Medical Record Notes
- Attendance Sheets
- Activity Records
- Time Slips
- Sign in logs/attendance sheets
- DME delivery tickets
- Trip Verification
- Monitoring Reports from Network Providers

Addressing Provider Performance Issues

The Provider Relations Department (Department) promptly notifies providers when any performance issues requiring action arise, documenting communications in the provider record (including the date, the individual communicated with, and a brief summary of issue and resolution).

The process for addressing performance issues involving member grievances is set forth in Anthem grievance policies and procedures, elaborated on above.

Progress on performance issues that are not grievance-related is regularly checked by the Department until the issue is fully resolved. Any issue that is unresolved for more than a month will result in written notification.

If necessary, the Department may follow up with active monitoring and intervention. This may include, but is not limited to:

- Communicating performance feedback to providers

- Provision of technical assistance or training, and
- A face-to-face meeting to rectify identified issues

A failure to resolve issues may result in the Department pursuing more serious measures. These include, but are not limited to:
- A formal review by Anthem Provider Performance Review Committee
- A formal notice of non-compliance to the provider, along with a request for corrective action plan
- A formal notice to the provider of Suspension of Participation or Pending Contract Termination

Quality Assurance and Performance Improvement (QAPI)

As part of Anthem Quality Assurance and Performance Improvement (QAPI) initiative, a committee of interdisciplinary professionals reviews provider metrics every quarter, including operational, clinical, and outcome data. The goal of the review is improvement of the quality and appropriateness of care, as well as an increase in member satisfaction.

Toward these ends, provider performance is evaluated according to these criteria:
- The quality and quantity of services rendered
- Provider's availability and accessibility
- Presence of any operational and clinical practice performance issues
- Timeliness and effectiveness of any performance issue resolution, and
- Both clinical and non-clinical member outcomes

Anthem supplies feedback to providers regarding their overall performance and on performance issues that require provider follow up. Such feedback may include, but is not limited to:
- Results from member satisfaction surveys, utilization reviews, and staff and member feedback
- Member grievances filed against the provider, and
- Non-compliance with contractual requirements or Anthem policies and procedures

Non-compliance or poor performance on the part of providers will result in a request for a corrective action plan by Anthem, and unsatisfactory progress may result in disciplinary action that includes suspension or termination of the provider agreement.

Consumer Directed Personal Assistance Program (CDPAP) Monitoring

Fiscal Intermediaries are educated and monitored to ensure compliance with all established requirements and guidelines.

Definitions and Acronyms

Self-Directing Consumer: an individual capable of making choices regarding their activities of daily living, including choices regarding the type, quality, and management of the consumer directed personal assistance, 2) who understands the impacts of these choices, and 3) is able to assume responsibility for the results of these choices.

Consumer: a recipient of medical assistance determined eligible to participate in the CDPAP by a social services district.

Consumer Directed Personal Assistant (CDPA): an adult who provides consumer directed personal assistance to a consumer under the instruction, supervision, and direction of either the consumer or the consumer's designated representative. Note that a consumer's spouse, parent, or designated representative may not serve as that consumer's CDPA. However, any other adult relative of the consumer may serve as the consumer's CDPA so long as the relative doesn't reside with the consumer. An exception to this last prohibition is made if the amount of care the Consumer requires makes it necessary for the relative to reside with the consumer.

Designated Representative: an adult of sufficient capability to whom a self-directing consumer has delegated authority to instruct, supervise, and direct the CDPA. With respect to a non-self-directing consumer, a *designated representative* is the consumer's parent, legal guardian, or, subject to the social services district's approval, a responsible surrogate who is willing and able to perform these responsibilities on the consumer's behalf. The designated representative may not be the CDPA, a Fiscal Intermediary's employee, representative, or affiliated person.

Stable Mental Condition: a condition that is not expected to exhibit sudden deterioration or improvement, and that does not require frequent medical evaluation in order to alter the consumer's plan of care.

Fiscal Intermediary (FI): an entity contracted with a social services district to provide wage and benefit processing for CDPAs.

Fiscal Intermediaries are audited upon contract approval and annually thereafter.

Collaboration with Anthem Team

Several Anthem departments work closely with providers to ensure members receive quality care. Below is a brief description of each of these departments.

Network and Provider Relations Department

The Network and Provider Relations Department maintains and supports Anthem provider network. The department is responsible for:

- Provider recruitment and contracting;
- Scheduling provider orientations and training to inform providers about Anthem programs, policies, and procedures;
- Developing communication initiatives to keep network providers informed and engaged, as well as issuing regular communications such as notices, updates, and information on general topics of interest;
- Ensuring providers receive notice of important changes in Anthem policies and procedures, of Anthem decisions regarding provider participation status, and of any compliance issues;
- Monitoring provider performance and facilitating resolution of Member grievances regarding provider performance;
- Answering provider questions and supplying technical assistance as necessary;
- Claims payment inquiries and resolutions, and
- Facilitating communication between providers and Anthem Care Management and Quality Assurance/Improvement personnel on care issues.

Care Management Department

The Care Management Department is responsible for planning and coordinating all aspects of member care. Every Anthem member is assigned a Care Management team consisting of a nurse care manager and a social worker. This team works with providers in the following ways:

- Makes provider referrals and works with providers to ensure service arrangements meet member needs
- Supplies required service authorizations
- Conveys pertinent member information to providers, enabling providers to render their services;
- Solicits input from providers on member status and needs
- Handles provider requests for service authorizations made on behalf of member

Member Services Department

The Member Services Department works with Anthem providers in the following ways:

- Supplies confirmation of member eligibility status
- Facilitates communication with member care management team
- Supplies assistance with special member needs, such as language translation services

Grievance and Appeal Units

The Grievance and the Appeals Units work with providers in the following ways:

- Handle any appeals providers file on behalf of members, and
- Review grievances relating to provider performance

Quality Assurance and Improvement Department

Through its oversight of Anthem operations and clinical practices, the Quality Assurance and Improvement Department ensures timely identification and resolution of issues affecting the quality of care supplied to Anthem members.

The Department works with providers in the following ways:

- Conducts audits both of member records and of operations at providers' sites
- Reviews quality of care supplied by providers
- Conducts member satisfaction surveys in conjunction with the Member Services and Provider Network Relations departments, assisting with the development and implementation of provider corrective action plans in response to negative feedback, and
- Supports the provider credentialing and re-credentialing processes

Anthem Partnership with You!

Anthem considers each of our providers a partner in caring for our members, so we work closely with them to ensure member needs are met. Only together can we maximize Member satisfaction and positive outcomes.

Committee Participation and Feedback Opportunities

To strengthen our partnership, we invite providers to provide feedback and participate on our committees. Opportunities include:

- Becoming a member of Anthem Quality Assurance Committee
- Providing feedback on or assisting in the design and planning of Quality Improvement initiatives
- Supplying feedback on your experience with Anthem through our provider satisfaction surveys

Please contact the Provider Relations Department for further information at **929-946-6500**.

Referral Process

Please refer to the Anthem MLTC Provider Portal User Guide posted on the MLTC Provider Portal at **mltcprovider.anthem.com** for an overview of the MLTC Provider Portal referral process. This website is for MLTC providers and services for Anthem.

After Anthem Receives the Referral

Once a referral is received, Anthem contacts the potential member within 48 hours in order to:

- Discuss the services Anthem offers and conduct eligibility screening
- Ensure newly eligible MLTC applicants are directed to Maximus for the Conflict Free Evaluation and Enrollment Center screening and CFEEC-UAS administration (New York Independent Assessor evaluation)
- Arrange to have an Assessment Nurse conduct a home visit/a video assessment, and
- Answer any questions the potential member may have

Marketing Guidelines for Anthem Providers

Anthem welcomes the assistance of provider partners in marketing Anthem services to eligible individuals, but providers must comply with marketing guidelines established by New York State.

These guidelines are as follows:

- Providers may not engage in marketing practices or distribute marketing materials that mislead, confuse or defraud eligible persons, the public, or any government agency.
- Providers may not misrepresent the Medicaid program, the Medicaid MLTC program, or policy requirements of the State or its agents (counties).
- Marketing materials must accurately reflect general information applicable to the average consumer, such as the plans providers have contracts with.
- Marketing activities may not discriminate on the basis of a potential member health status, prior health service use, or need for future health care services.
- Plans or Providers may not conduct “cold call” telephone solicitations. Door to door solicitation is also prohibited.
- Providers may not provide mailing lists of their patients to Anthem or any other Plan.
- Providers may not disseminate any information regarding mandatory enrollment requirements.
- Providers may give permission to Anthem marketing representatives to conduct marketing activities at their facilities. If Anthem participates in these activities, Anthem must prominently display a list of all other Plans operating in the county or borough.
- Anthem will not require providers to distribute Anthem-prepared communications to their patients.
- In the event that providers are no longer affiliated with a particular Plan, but remain affiliated with other participant Plans, providers may notify their patients of their new status and the impact the change has on the patient.
- All marketing activities shall be conducted in an orderly and non-disruptive manner and shall not interfere with the privacy of potential enrollees or the general community.

- Providers may not offer material or financial gain to Medicaid beneficiaries as an inducement to enroll. Specifically, providers and Plans may only:
  - Make reference in marketingmaterials and activities to benefits/services offered under the program, and
  - Offer nominalgifts with a fair market value of no more than $5.00, and such gifts must be offered regardlessof a potential enrollee's intent to enroll.
- Providers shall not pay any individual, or accept in payment from a Plan, any commission, bonus, or similar compensation based on numbers of referrals or Medicaid-eligible persons enrolled in the MLTC.

REMINDER: Medicaid recipients may never be told by their provider that they have to join a plan immediately. Recipients have to make a selection when they receive their official notice from the State or its designees or are seeking community-based long-term care services in mandatory counties.

Exhibit A

PHYSICIAN'S ORDER FOR PERSONAL CARE/CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES

COMPLETE ALL ITEMS INCOMPLETE FORMS WILL BE RETURNED TO THE PHYSICIAN

1. Patient Identifying Information (Use additional paper if necessary)

PATIENT NAME		CIN	DATE OF BIRTH	SEX
ADDRESS APT/STREET CITY STATE ZIP CODE				
TELEPHONE NO. ( )	MEDICARE NO.	IF CURRENTLY HOSPITALIZED: Name of Hospital	DATE OF ADMISSION:	ANTICIPATED DATE OF DISCHARGE
TO ABOVE ADDRESS? □ YES □ NO IF NO EXPLAIN:				

2. General Information

PHYSICIAN NAME	LICENSE #	TELEPHONE NO. ( )
ADDRESS STREET CITY STATE ZIP CODE		
If the examination was conducted by a Physician's Assistant, Specialist's Assistant, or Nurse Practitioner, Identify: Name _____ Profession:_____ License #:_____		
PLACE OF EXAMINATION:_____ DATE OF EXAMINATION:_____ (30 days of Physician's signature date)		

3. Medical Findings

NOTE: Indicate **N/A** if an item does not apply to this patient or **Unk** if the requested information is unknown to the physician signing this form.

Height:_____ Weight:_____

For the condition(s) requiring personal care:

Primary Diagnosis _____ ICD-9-CM Code_____

Secondary Diagnosis_____ ICD-9-CM Code_____

Describe the patient's current medical/physical condition_____

_____

_____

Is the patient's condition stable? □ YES □ NO

Is the patient appropriate for Hospice Care? □ YES □ NO

Describe the current treatment plan and therapeutic goals including the prognosis for recovery: _____

_____

_____

Describe any prohibited activities or functional limitations: _____

_____

_____

Is the patient self-directing? □ YES □ NO

Is the patient able to summon help by any means? □ YES □ NO

If No, explain _____

_____

Is the patient able to ambulate independently? □ YES □ NO With devices? □ YES □ NO Other Assistance? □ YES □ NO

Describe: _____

_____

Is the patient continent of bowel? □ YES □ NO Of bladder? □ YES □ NO

Catheter/Colostomy Needs: _____

List all current medications (prescription and OTC) and note dosage and frequency and any special instructions (attach additional sheet if necessary):

_____

_____

_____

_____

Can the patient self-administer medications: □ YES □ NO

If the patient requires a modified diet or has other special nutritional or dietary needs, describe:_____

_____

_____

Please indicate any task, treatments or therapies currently received, or required by the patient: _____

_____

_____

_____

Does the patient require assistance with, or provision of, skilled tasks (e.g. monitoring of vital signs, dressing changes, glucose monitoring, etc.)?

□ YES □ NO If Yes, please indicate: _____

_____

_____

Based on the medical condition, do you recommend the provision of service to assist with skilled tasks, personal care and/or light housekeeping tasks?

□ YES □ NO

Contributing Factors:

Describe contributing factors including but not limited to the social, family, home or medical (e.g. muscular/motor impairments, poor range of motion, decreased stamina, etc.) situation that may affect the patient's ability to function, or may affect the need for home care or that may affect the patient's need for assistance with skilled tasks, personal care tasks and/or light housekeeping. Please include any other information that may be pertinent to the need for assistance with home care services.

_____
_____
_____
_____
_____
_____
_____
_____

IT IS MY OPINION THAT THIS PATIENT CAN BE CARED FOR AT HOME. I HAVE ACCURATELY DESCRIBEDHIS OR HER MEDICAL CONDITION. NEEDS AND REGIMENS, INCLUDING ANY MEDICATION REGIMENTS, AT THE TIME I EXAMINED HIM OR HER. I UNDERSTAND THAT I AM NOT TO RECOMMEND THE NUMBER OF HOURS OF PERSONAL CARE SERVICES THIS PATIENT MAY REQUIRE. I ALSO UNDERSTAND THAT THIS PHYSICIAN'S ORDER IS SUBJECT TO THE NEW YORK STATE DEPARTMENT OF HEALTH REGULATIONS AT PARTS 515, 516, 517 AND 518 OF TITLE 18NYCRR, WHICH PERMIT THE DEPARTMENT TO IMPOSE MONETARY PENALTIES ON, OR SANCTION AND RECOVER OVERPAYMENTS FROM PROVIDERS OR PRESCRIBERS OF MEDICAL CARE, SERVICES OR SUPPLIES THAT ARE UNNECESSARY, IMPROPER OR EXCEED THE PATIENT'S DOCUMENTED MEDICAL CONDITION ARE PROVIDED OR ORDERED.

INCOMPLETE OR MISSING INFORMATION MAY DELAY SERVICES TO THIS PATIENT

Physician's Signature _____ Date _____
(Must be within 30 days of date of examination)

PLEASE SIGN AND RETURN COMPLETED FORM WITHIN 30 CALENDAR DAYS OF EXAMINATION TO:

_____

_____
_____

New York State Department of Health

PHYSICIAN'S ORDER FOR PERSONAL CARE/CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES

INSTRUCTIONS

COMPLETE ALL ITEMS. *(Attach additional sheets, if necessary)*. INCOMPLETE FORMS WILL BE RETURNED TO THE PHYSICIAN. INCOMPLETE OR MISSING INFORMATION MAY DELAY SERVICES TO THIS PATIENT.

1. **Patient Identifying Information**
   - **Patient Name.** Enter the patient's name.
   - **CIN.** Found on the patient's Medical Assistance ID card.
   - **Date of Birth.** Enter the patient's date of birth.
   - **Sex.** Enter the patient's gender.
   - **Address and telephone number.** Enter the patient's address and telephone number.
   - **Medicare #.** Enter the patient's Medicare number if available.
   - **If currently hospitalized.** If the patient is hospitalized at the time of completion of the physician's order, indicate the name of the hospital, date of admission, and anticipated date of discharge.
   - **Discharge to above address. I**f the patient is to be discharged to an address other than the address listed above please explain.
   - General Information
2. **Physician's Name, License #, Address, Telephone**. Enter information for the physician signing the order. Enter either the physician's license number as issued by the New York State Department of Education or the provider billing number issued by the New York State Department of Health Medicaid Management Information System.

   - **Examination conducted by other than a physician**. If patient was examined, and the order form completed by a physician's assistant, specialist's assistant, or nurse practitioner, complete the required information.

   - **Place of Examination.** Indicate the location (office, clinic, home, etc) of the examination of the patient.

   - **Date of Examination**. Enter the date the patient was examined. This must be within 30 days of the date the physician signed the form.

3. **Medical Findings**

Note: Indicate **N/A** if an item does not apply to this patient or **Unk** if the requested information is unknown to the physician signing this form.

   - **Height, Weight.** Enter the patient's height and weight.

- **Primary and Secondary Diagnosis.** Enter the primary and secondary diagnosis with ICD-9-CM codes for the primary and secondary conditions which result in the patient being evaluated for home care services.

- **Describes the current condition.** Describe the patient's current medical/physical condition, including any relevant history.

- **Stability.** Check **Yes** if the patient's condition is not expected to show marked deterioration or improvement. **A stable medical condition** shall be defined as follows:
  (a) the condition is not expected to exhibit sudden deterioration or improvement; and
  (b) the condition does not require frequent medical or nursing judgment to determine changes in the patient's plan of care; and
  (c) (1) the condition is such that a physically disabled individual is in need of routine supportive assistance and does not need skilled professional care in the home; or
  (2) the condition is such that a physically disabled or frail elderly individual does not need professional care but does require assistance in the home to prevent a health or safety crisis from developing.

- **Hospice.** If the patient's condition is terminal, indicate if the patient is appropriate for Hospice services.

- **Describe the current treatment plan**. Include therapeutic goals and prognosis for recovery and anticipated duration of the current treatment plan.

- **Limitations.** Indicate any functional limitations or prohibited activities.

- **Self-Directing.** Indicate if the patient is self-directing. Self-directing means that the patient is capable of making choices about activities of daily living, understanding the impact of the choices, and assuming responsibility for the results of the choices. A **No** response to this item should be reflected in the description of the patient's condition as documented in the applicable section.

- **Able to Summon Help.** Check **Yes** if the patient is able to summon assistance in an emergency situation by any means. If the patient is not able to summon assistance, check **No** and explain.
- **Ambulation.** Indicate the patient's ability to ambulate independently, or with the need for assistance or devices. Specify assistance/devices used or needed.

- **Bowel/Bladder.** Indicate if the patient is continent. Describe any catheter or colostomy needs.

- **Medications Required**. List all prescription and over-the-counter medications the patient is taking and note dosage, frequency and any special instructions.

- **Medication Administration**. Indicate the patient's ability to self-administer medications.

- **Dietary Needs.** Indicate if the patient has special nutritional or dietary needs, i.e. low salt or high potassium.

- **Tasks/Treatments/Therapies.** Indicate any tasks, treatments or therapies which the patient receives or requires in the home and describe.

- **Need for completion/assistance with skilled tasks.** If the patient requires assistance with skilled tasks including, but not limited to, glucose monitoring, wound care, vital signs, describe the need for such assistance.

- **Recommendation to provide assistance.** Check **Yes** if, in your opinion, the patient can be maintained in his or her home with provision of home care services.

- **Contributing factors to need for assistance**. Please indicate the functional deficits that support the need for the provision of home care services. Please include any pertinent information you may have regarding the patient's surroundings, physical condition or other factors that may affect the ability of the patient to function in the community or the patient's need for assistance with personal care tasks.

4. **Physician's Signature/Date of completion.** The signature of the ordering physician as identified in Item 2. Note that by signing this document, the physician certifies that the patient's condition and needs are accurately described. Forms lacking a signature and/or date are not acceptable.

5. **Return Form To.** The local district or other case management entity to whom the form is to be returned.

Exhibit B
PROVIDER FILE CHANGE FORM

Please use this form in place of your office letterhead when submitting changes to Anthem. All fields must be completed to process the request. Please print clearly and legibly. You must include a signed and dated W9 and your current Liability Insurance face sheet showing amounts and expiration date.

Type of Change: □ Add □ Change □ Delete Effective Date of Change: _____
Month/Day/Year

SECTION 1: Current Information

Legal Facility /
Organization Name: _____

d/b/a Trade Name: _____

Street Address: _____

City/State/Zip Code + 4: _____

Phone #: _____ Fax #: _____

TIN: _____ NPI:_____

Email:_____

SECTION 2: New Office Information

Legal Facility /
Organization Name: _____

d/b/a Trade Name: _____

Street Address: _____

City/State/Zip Code + 4: _____

Phone #: _____ Fax #: _____

TIN: _____ NPI:_____

Other:_____

You may return this form along with your signed and dated W9 and Liability Insurance face sheet to the Provider Relations Department by:

Fax: (718) 368-6269 or Email: providerrelations3@anthem.com

By signing this form, you are authorized on behalf of your organization and attest this information is accurate and correct.

Name (please print):_____

Signature:_____

Date of Request: _____

Hours of Operation & Contact Information

Anthem normal hours of operation are Monday through Friday, 9 a.m. to 5 p.m. EST.

Provider Relations

General Questions	Tel: **929-946-6500** Fax: **718-368-6269** Email: providerrelations3@anthem.com
Policies and Procedures	
Provider Orientation and Training	
Credentialing and Re-credentialing	
Claims and Payments	
Performance Management	

For inquiries regarding enrollment, eligibility, benefits, authorizations, claims, and appeals, please call Anthem's Provider Service Line at **929-946-6500**.

Fax service requests and all clinical documentation to Anthem's Care Management team at **718-368-6267**.

Send CDPAS Physician Orders to MLTCCDPAS@Anthem.com.

Provider Services: 800-450-8753
https://providers.anthem.com/ny