Anthem • New York | Medicaid

Provider Manual

Anthem

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

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1 INTRODUCTION

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

We are a licensed health maintenance organization (HMO). We bring the best expertise available nationally to operate local, community-based healthcare plans with experienced local staff to complement our operations. We are committed to assisting you in providing quality healthcare.

We believe hospitals, physicians and other providers play a pivotal role in managed care. We can only succeed by working collaboratively with you and other caregivers. Earning your loyalty and respect is essential to maintaining a stable, high-quality provider network.

If you are interested in participating in any of our quality improvement committees or learning more about specific policies, please contact us. Most committee meetings are prescheduled at times and locations intended to be convenient for you. Please call Provider Services at **800-450-8753** with any suggestions, comments, or questions that you may have. Together, we can arrange for and provide an integrated system of coordinated, efficient and quality care for our members and your patients.

Anthem complies with all New York State Medicaid and federal guidelines and incorporates them into our policies and procedures. As such, we require providers rendering care to our members to adhere to these guidelines, policies, and procedures. Please note this provider manual will be amended as our operational policies change. We will notify you by mail, phone, or email.

If you believe you do not have our most current edition of our manual, please email us at nyproviderrequests@anthem.com to receive a new one.

2 OVERVIEW

Who is Anthem Blue Cross and Blue Shield HP?

As a leader in managed healthcare services for the public sector, Anthem's Corporation's subsidiary health plans provide healthcare coverage exclusively to low-income families, seniors, and people with disabilities. Anthem is an award-winning Prepaid Health Service Plan (PHSP) that provides and manages government-sponsored health insurance programs to eligible members in the five boroughs of New York City as well as Nassau, Suffolk, Westchester, and Putnam counties. Currently, we provide Child Health Plus (CHPlus), Medicaid Managed Care (MMC) and Managed Long-Term Care (MLTC)/Medicaid Advantage Plus (MAP) services to over 400,000 members and are one of the largest health plans in New York City.

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

Mission

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

Strategy

Our strategy is to:

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

Summary

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

3 QUICK REFERENCE INFORMATION

Please call Provider Services at the National Customer Care department for precertification/notification, health plan network information, member eligibility, claims information, inquiries, and recommendations you may have about improving our processes and managed care program.

Anthem Phone Numbers

Provider Services telephone:	**800-450-8753**
Provider Services fax:	**800-964-3627**
TTY:	**711**
Automated Provider Inquiry Line for Member Eligibility:	**800-450-8753**
Electronic Data Interchange (EDI) - Availity Client Services:	**800-282-4548**
24/7 NurseLine:	**800-300-8181**
Member Services:	**800-300-8181**
Pharmacy Services for CHPlus only:	**800-450-8753**
Pharmacy Services for NY Medicaid and HARP Through NYRx	**877-309-9493**
Appeals Inquiry:	**866-696-4701**

Other Contact Information

Availity Client Services (secure provider platform)

- **800-AVAILITY**
- **https://Availity.com**

Superior Vision (vision services):

- Member Services: **800-428-8789**
- Provider Services: **800-243-1401**
- Website: **superiorvision.com**

LIBERTY Dental Plan (dental services):

- Members: **833-276-0847**
- Providers: **833-276-0853**
- Website: **libertydentalplan.com**

Carelon Medical Benefits Management, Inc. (radiology services, radiology, cardiology studies, musculoskeletal (MSK) pain and spine management, genetic testing, sleep studies, and outpatient rehab [PT, OT, ST]):

- Providers: **800-714-0040**. The call center will be open to take calls 8 a.m. to 8 p.m. Eastern time.
- Members: **800-252-2021**
- Web portal: **www.providerportal.com**

HearUSA (hearing services):

- Phone: **800-333-3389** (**888-300-3277** for TDD relay services)
- Website: **HearUSA.com**

CarelonRx mail order: **833-203-1737 — Only available for CHPlus**

Medical Answering Services, LLC (nonemergent transportation):

- Phone:
  - MMC members in the five boroughs: **844-666-6270**
  - All other MMC members: **800-850-5340**
- Fax: **315-299-2786**
- Mailing Address: Medical Answering Services, LLC
  P.O. Box 12000
  Syracuse, NY 13218
- Website: **medanswering.com**

Our website contains a full complement of resources, including inquiry tools for real-time eligibility, claims status, and referral authorization status. In addition, the website provides general information you'll find helpful such as forms; the *CHPlus Preferred Drug List* (*PDL*); drugs requiring prior authorization for CHPlus members; provider manuals; referral directories; provider newsletters; claim status, electronic remittance advice (ERA) and electronic funds transfer (EFT) information; updates; *Clinical Guidelines* and other information to help us collaborate with you. Visit **https://providers.anthem.com/ny** to learn more.

Ongoing Provider Communications

To ensure you're up-to-date with information required to work effectively with us and our members, we periodically post information on our website, and send you broadcast faxes, provider manual updates, and newsletters.

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

Additional information	
Member eligibility	• Use Availity Essentials to verify member eligibility. Log in to **https://Availity.com** and select **Patient Registration** > **Eligibility and Benefits**. • Contact the Provider Inquiry line at **800-450-8753**.
Physical health notification/precertification	• May be telephoned, submitted online, or faxed to Anthem: o Telephone: **800-450-8753** o Web: **https://Availity.com** o Fax: **800-964-3627** • Data required for complete notification/precertification: o Member ID number o Legible name of referring provider o Legible name of individual referred to provider o Number of visits/services o Date(s) of service o Diagnosis o CPT® code • In addition, clinical information is required for precertification. Precertification forms are located on our website.

Additional information	

Claims information	• Online:
	  ○ Electronic claims payer IDs:
	  ▪ For professional claims: 00803
	  ▪ For institutional claims: 00303
	• Submit paper claims to:
	Anthem
	P.O. Box 61010
	Virginia Beach, VA 23466-1020
	• Timely filing is within 90 days from the date of service, or per the terms of the *Provider Agreement*.
	• Anthem provides an online resource designed to significantly reduce the time your office spends verifying eligibility, claims status, authorization reviewing/responding to Digital Request for Additional Information (RFAI). Log in to our website and browse through the *Tools* section for more details.
	• If you are unable to access the internet, you may receive claims status, eligibility verification, and authorization status over the telephone at any time by calling our toll-free, automated Provider Inquiry line at **800-450-8753**.

Medical appeal information	• Medical appeals must be filed (i.e., received by the health plan) within 60 calendar days of the date of the notice of action for Medicaid Managed Care and within 180 days of the notice of action for Child Health Plus. • File a standard medical appeal at: Anthem Medical Appeals P.O. Box 62429 Virginia Beach, VA 23466-2429 • Fax an **Expedited Appeal** only to **866-495-8716**
Payment disputes	• You have 30 calendar days from receipt of *Explanation of Payment* (*EOP*) to request an informal claim dispute resolution review. We must receive your request before the end of the 30 days. Anthem will send a determination letter within 30 business days of receiving all necessary information. If you're dissatisfied with the resolution, you may submit an appeal of the resolution within 60 calendar days of receipt of the notification. We must receive your appeal before the end of the 60 days. • Locate the claim you want to dispute on Availity Essentials using **Claim Status** from the *Claims & Payments* menu. If available, select **Dispute Claim** to initiate the dispute. Go to **Request** to navigate directly to the initiated dispute in the appeals dashboard, add the documentation, and submit. • File a payment dispute at: Anthem Payment Disputes P.O. Box 61599 Virginia Beach, VA 23466-1599

Additional information	
Provider grievances	• Provider grievances should be submitted to: Anthem Grievances and Appeals PENN 1, 35th Floor New York, NY 10119 Email: nyproviderinquiries@anthem.com
Provider changes	• Providers should immediately submit any changes to demographics, specialty, practice information, TIN, billing, office hours, or appointment scheduling phone number directly to Anthem. The *Practice Profile Form* can be downloaded from the provider website and sent via email to nyproviderprofiles@anthem.com.
Case managers	• Anthem case managers are available during normal business hours from 9 a.m. to 5 p.m. ET. • For urgent issues, assistance is available after normal business hours and on weekends and holidays through Member Services at **800-300-8181**.
Provider service representatives	For more information, contact Provider Services at **800-450-8753**.
Pharmacy	**800-450-8753 for CHPlus only** **877-309-9493 for Medicaid and HARP through NYRx**
24/7 NurseLine	**800-300-8181**
Anthem Managed Long-Term Care (MLTC)/Anthem Medicaid Advantage Plus (MAP)	**800-950-7679**
New York State Department of Health	**800-206-8125**
Behavioral health precertification	**800-450-8753** Can also be submitted digitally using our preferred method via Availity Essentials **(https://Availity.com)**
New Baby, New Life Program	**800-450-8753**
Chief Compliance Officer	ethics@anthem.com
Report fraud	**866-847-8247** or **Report Form | Fraud, Waste & Abuse (fighthealthcarefraud.com)**; Anthem Customer Service at **800-450-8753**; participating providers may call the Provider Inquiry line at **800 450 8753**.
Condition Care	**888-830-4300**
WIC program	**health.state.ny.us/prevention/nutrition/wic**
Clinical Practice Guidelines	**800-450-8753**
Domestic Violence Coordinator	**800-450-8753**

Provider and Facility Digital Guidelines

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

Anthem expects Providers and Facilities will utilize digital tools, unless otherwise prohibited by law or other legal requirements.

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

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

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

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

Digital guidelines available through Availity Essentials include:

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

Additional digital applications available to Providers and Facilities include:

- Pharmacy prior authorization drug requests
- Services through Carelon Medical Benefits Management, Inc.
- Services through Carelon Behavioral Health, Inc.

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

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

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

Section 1: Accepting digital ID cards

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

Section 2: Eligibility and benefits inquiry and response

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

- EDI transaction: X12 270/271 – eligibility inquiry and response
    - Anthem supports the industry standard X12 270/271 transaction set for eligibility and benefit inquiry and response as mandated by HIPAA.
- Availity Essentials
    - The Eligibility and Benefits Inquiry verification application allows a Provider and Facility to key an inquiry directly into an online eligibility and benefit look-up form with real-time responses.
- Provider desktop integration via B2B APIs
    - Anthem has also enabled real-time access to eligibility and benefit verification APIs that can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration opportunities.

Section 3: Prior authorization submission, attachment, status, and clinical appeals.

Providers and Facilities should leverage these channels for prior authorization submission, status inquiries and to submit electronic attachments related to prior authorization submissions:

- EDI transaction: X12 278 – prior authorization and referral:
    - Anthem supports the industry standard X12 278 transaction for prior authorization submission and status inquiry as mandated per HIPAA.
- EDI transaction: X12 275 – patient information, including HL7 payload for authorization attachments:
    - Anthem supports the industry standard X12 275 transaction for electronic transmission of supporting authorization documentation including medical records via the HL7 payload.

- Availity Essentials:
    - Authorization applications include the Availity Essentials multi-payer Authorization and Referral application for authorization submissions not accepted through Availity Essentials' multi-payer application.
        - Both applications enable prior authorization submission, authorization status inquiry and the ability to review previously submitted authorizations.
- Provider desktop integration via B2B APIs:
    - Anthem has enabled real-time access to prior authorization APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

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

Claim submissions status and claims payment disputes

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

- EDI transaction: X12 837 – Professional, institutional, and dental Claim submission (version 5010):
    - Anthem supports the industry standard X12 837 transactions for all fee-for-service and encounter billing as mandated per HIPAA.
    - 837 Claim batch upload through EDI allows a provider to upload a batch/file of Claims (must be in X12 837 standard format).
- EDI transaction: X12 276/277 – Claim status inquiry and response:
    - Anthem supports the industry standard X12 276/277 transaction set for Claim status inquiry and response as mandated by HIPAA.
- Availity Essentials: The Claims & Payments application enables a provider to enter a Claim directly into an online Claim form and upload supporting documentation for a defined Claim.
    - Claim Status application enables a provider to access online Claim status. Access the Claim payment dispute tool from Claim Status. Claims Status also enables online claim payment disputes in most markets and for most claims. It is the expectation of Anthem that electronic Claim payment disputes are adopted when and where it is integrated.
- Provider desktop integration via B2B APIs:
    - Anthem has also enabled real-time access to Claim Status via APIs, which can be directly integrated within participating vendor's practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

Claim attachments

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

- EDI transaction: X12 275 – Patient information, including HL7 payload attachment:
    - Anthem supports the industry standard X12 275 transaction for electronic transmission of supporting Claim documentation including medical records via the HL7 payload.
- Availity Essentials – Claim Status application enables a Provider or Facility to digitally submit supporting Claims documentation, including medical records, directly to the Claim.
    - Digital Request for Additional Information (Digital RFAI) – The Medical Attachments application on Availity Essentials enables the transmission of digital notifications when additional documentation including medical records are needed to process a Claim.

Section 5: Electronic remittance advice and electronic claims payment

Electronic remittance advice

Electronic remittance advice (ERA) is an electronic data interchange (EDI) transaction of the explanation of payment of your claims. Anthem supports the industry standard X12 835 transaction as mandated per HIPAA.

Providers and Facilities can register, enroll and manage ERA preference through **Availity.com**. Printing and mailing remittances will automatically stop thirty (30) days after the ERA enrollment date.

- Viewing an ERA on Availity Essentials is under Claims & Payments, Remittance Viewer. Features of remittance viewer, include the ability to search a two (2) year history of remittances and access the paper image.
- Viewing a portable document format (PDF) version of a remit is under Payer Spaces which provides a downloadable PDF of the remittance.

To stop receiving ERAs for your claims, contact Availity Client Services at **1-800-AVAILITY** (282-4548).

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

Electronic claims payment

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

- **Electronic Funds Transfer (EFT)**

  Electronic funds transfer (EFT) uses the automated clearinghouse (ACH) network to transmit healthcare payments from a health plan to a Provider's or Facility's bank account at no charge for the deposit. Health plans can use a Provider's or Facility's banking information only to deposit funds, not to withdraw funds. The EFT deposit is assigned a trace number (TRN) to help match the payment to the correct 835 electronic remittance advice (ERA), a process called reassociation.

  To enroll in EFT: Providers and Facilities can register, enroll, and manage account changes for EFT through EnrollSafe at **enrollsafe.payeehub.org**. EnrollSafe enrollment eliminates the need for paper registration. EFT payments are deposited faster and are generally the lowest cost payment method. For help with enrollment, **use this convenient EnrollSafe User Reference Manual**.

To disenroll from EFT: Providers and Facilities are entitled to disenroll from EFT. Disenroll from EFT payments through EnrollSafe at **enrollsafe.payeehub.org**.

- **Virtual Credit Card (VCC)**

  For Providers and Facilities who don't enroll in EFT, and in lieu of paper checks, Anthem is shifting some reimbursements to virtual credit card (VCC). VCC allow Providers and Facilities to process payments as credit card transactions. Check with your merchant processor regarding standard transaction fees that will apply.

  Note that Anthem may receive revenue for issuing a VCC.

  Opting out of virtual credit card payment. Providers and Facilities are entitled to opt out of electronic payment. To opt out of virtual credit card payment, there are two (2) options:

  - Enrolling for EFT payments automatically opts you out of virtual credit card payments. To receive EFT payments instead of virtual credit cards payments, enroll for EFT through EnrollSafe at **enrollsafe.payeehub.org**.

  OR

  - To opt out of virtual credit card payments, call **800-833-7130** and provide your taxpayer identification number.

- **Zelis Payment Network (ZPN) electronic payment and remittance combination**

  The Zelis Payment Network (ZPN) is an option for Providers and Facilities looking for the additional services Zelis can offer. Electronic payment (ACH or VCC) and Electronic Remittance Advice (ERA) via the Zelis portal are included together with additional services. For more information, go to **Zelis.com**. Zelis may charge fees for their services.

  Note that Anthem may receive revenue for issuing ZPN.

  ERA through Availity is not available for Providers and Facilities using ZPN.

  To disenroll from ZPN payment, there are two (2) options:

  - Enrolling for EFT payments automatically removes you from ZPN payments. To receive EFT payments instead of ZPN payments, enroll for EFT through EnrollSafe at **enrollsafe.payeehub.org**.

  OR

  - To disenroll from ZPN payments, update your Zelis registration on the Zelis provider portal or contact Zelis at **877-828-8770**.

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

4 PRIMARY CARE PROVIDERS

Primary Care Providers

The PCP is a provider who serves as the entry point into the healthcare system for the member. The PCP is responsible for the complete care of their patient, including but not limited to providing primary care, coordinating and monitoring referrals to specialty care, authorizing hospital services, and maintaining the continuity of care. Below are highlights of the PCP's responsibilities (this includes Voluntary Foster Care Agencies [VFCA]).

PCP responsibilities shall include, at a minimum:

- Managing the medical and healthcare needs of members to ensure all medically necessary services are made available in a timely manner.
- Monitoring and following up on care provided by other medical service providers for diagnosis and treatment to include services available under Fee-For-Service (FFS) Medicaid.
- Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services that may be available through FFS Medicaid.
- Maintaining a medical record of all services rendered by the PCP and other referral providers.
- Screening and treating patients for sexually transmitted diseases (STDs), reporting cases of STDs to the local public health agency, and cooperating in contact investigations in accordance with existing state and local laws and regulations.
- Educating patients about the risk and prevention of sexually transmitted diseases (STDs).

A PCP must be a physician or network provider/subcontractor who provides or arranges for the delivery of medical services, including case management, to ensure all services which are found to be medically necessary are made available in a timely manner. The PCP may practice in a solo or group setting or may practice in a clinic (for example, a Federally Qualified Health Center [FQHC] or Rural Health Center [RHC]) or outpatient clinic including Voluntary Foster Care Agencies (VFCAs).

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

Provider Specialties

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

- Family practitioner
- General practitioner
- General pediatrician
- General internist
- Nurse practitioners certified as specialists in a family practice or pediatrics
- FQHCs and RHCs
- Voluntary Foster Care Agency (VFCA)

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

PCP Onsite Availability

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

- Enrollees must have access to an after-hours live voice for PCP and OB/GYN emergency consultation and care.
- PCPs must offer 24 hour-a-day, 7 day-a-week telephone access for members.
- A 24-hour telephone service may be used if it is:
    - Answered by a designee such as an on-call physician or nurse practitioner with physician backup, or an answering service or answering machine. Note: If an answering machine is used, the message must direct the member to a live voice.
    - Maintained as a confidential line for member information and/or questions; an answering machine is **not** acceptable.
- The PCP or another physician/nurse practitioner must be available to provide medically necessary services.
- Covering physicians are required to follow the preauthorization guidelines.
- It is **not** acceptable to automatically direct the member to the emergency room when the PCP is not available.
- We encourage our PCPs to offer after-hours office care in the evenings and on weekends.

Member Enrollment

Member enrollment into Anthem is voluntary. Members who meet the state's eligibility requirements for participation in managed care are eligible to join Child Health Plus, Medicaid Managed Care and Managed Long-Term Care/Medicaid Advantage Plus through our healthcare plan. Eligible members are enrolled without regard to health status.

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

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

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

- Through the OCR complaint portal at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**

- By mail to: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201
- By phone at: **800-368-1019 (TTY/TTD: 800-537-7697)**

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

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

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

- Mail: PENN 1, 35th Floor New York NY 10119
- Phone: **212-563-5570, ext. 66578**

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

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

Health Plan Products and Benefits
Child Health Plus (CHPlus) is a New York state-sponsored, free or low-cost health insurance program available to members ages 0 to 19 of low-income families who are not eligible for Medicaid and do not have other health insurance.

Medicaid Managed Care is available to eligible Medicaid recipients residing within the Anthem service area.

Managed Long-Term Care (MLTC) is available to Medicaid recipients who meet medical criteria and reside within the service area. The minimum age for joining an MLTC plan is 18 years of age. The program is known to members and participating providers as Anthem Managed Long-Term Care. Please refer to the Anthem MLTC provider reference guide for program information, including benefits, care coordination and provider responsibilities. If you do not have a copy of our MLTC provider reference guide and would like to obtain one, please contact our MLTC Services department at **800-950-7679**.

Any patient with HIV or AIDS, whose local district of residence qualifies them for enrollment in an HIV Special Needs Plan (HIV SNP), may request transfer from an MCO to an HIV SNP or from one HIV SNP to another at any time.

Medicaid Advantage Plus (MAP) is a Managed Long Term Care plan available to members who have both Medicaid and Medicare and reside within the service area. The minimum age for joining MAP is 18 years of age. The program is known to members and participating providers as Medicaid Advantage Plus. Please refer to the Anthem Mediblue HealthPlus Dual Plus documents for program information including benefits, care coordination and provider responsibilities. If you do not have a copy of our MLTC/MAP provider reference guide and would like to obtain one, please contact our MLTC/MAP Services department at **800-950-7679**.

New York Behavioral Health and the Health and Recovery Plan (HARP) is an enhanced benefit package for members with complex behavioral health needs. It is made up of physical health, behavioral health, pharmacy, and waiver services. HARP is for adults who have certain health conditions. These conditions are set by the state. HARP helps members get the care they need while keeping them in their homes and communities.

Member Disenrollment

A member can be disenrolled from the health plan in limited circumstances. If you believe a member should be disenrolled for a medical reason or for noncompliance, please contact Member Services at **800-300-8181** for assistance. **Note: MLTC/MAP and CHPlus are voluntary programs. A member may choose to disenroll from Anthem at any time.**

Newborn Enrollment

We will enroll and provide coverage for eligible newborn children effective from the date of birth. Upon notification of the birth by the hospital, the New York State Department of Health (NYSDOH) will enroll the newborn in the mother's healthcare plan. If the newborn is not identified as SSI or SSI-related and therefore excluded from a healthcare plan pursuant to Section 2(b)(xi), the newborn will be retroactively enrolled to the first day of the month of birth.

Based on the transaction date of the enrollment of the newborn, the newborn will appear on either the next month's roster or the subsequent month's roster.

Member Eligibility Listing

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

To request a hard copy of your panel listing be mailed to you, call Provider Services.

Member Identification Cards

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

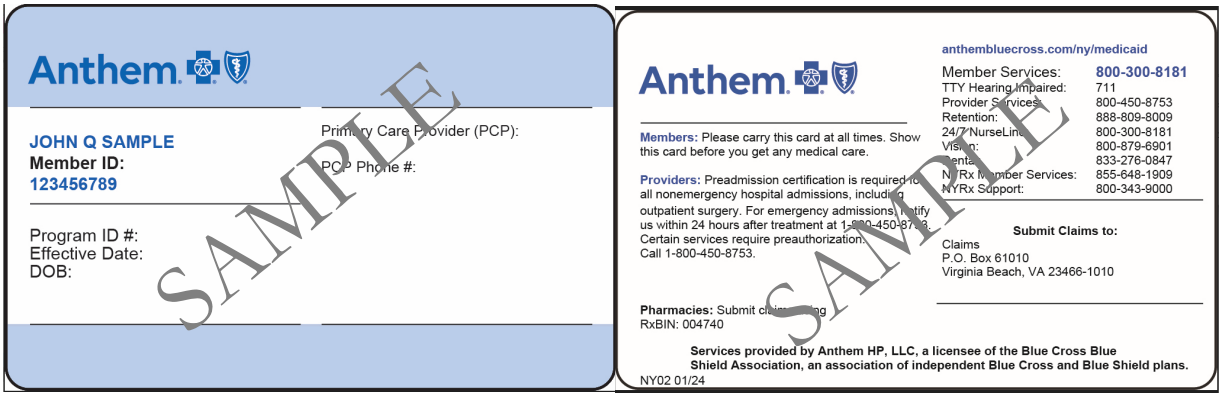
- The member's ID number
- The member's name (first name, last name and middle initial)
- The member's date of birth
- The member's enrollment effective date
- Toll-free phone numbers for information and/or authorizations
- Toll-free 24/7 NurseLine, available 24 hours a day, 7 days a week
- Descriptions of procedures to be followed for emergency or special services
- Anthem address and telephone number
- PCP name and telephone number

Our members also have access to:

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

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

Medicaid Managed Care Member ID Card



Americans with Disabilities Act Requirements

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

- Street-level access

- An elevator or accessible ramp into facilities
- Access to a lavatory that accommodates a wheelchair
- Access to an examination room that accommodates a wheelchair
- Handicap parking clearly marked, unless there is street-side parking

Medically Necessary Services

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

- Services are essential to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, result in illness or infirmity of a member, or interfere with such person's capacity for normal activity.
- Services are provided at an appropriate facility and at the appropriate level of care for the treatment of the member's medical condition.
- Services are provided in accordance with generally accepted standards of medical practice.
- For children and youth, medically necessary means healthcare and services that are necessary to promote normal growth and development and prevent, diagnose, treat, ameliorate, or palliate the effects of a physical, mental, behavioral, genetic or congenital condition, injury, or disability.

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

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

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

Member Complaint Procedures

A complaint is an expression of dissatisfaction by a member or provider on a member's behalf about care and treatment that does not amount to a change in scope, amount, or duration of service.

Filing a Complaint
A complaint may be issued verbally or in writing. Verbal complaints should be made by contacting us by phone or in writing at the following address:

Anthem Grievances and Appeals
Member Complaint Specialist
Quality Management Department
PENN 1, 35th Floor
New York, NY 10119

If assistance is needed to file a grievance or complaint, we can help. Please call:
Member Services: **800-300-8181**
Provider Services: **800-450-8753**

We will designate one or more qualified staff members who were not involved in any previous level of review or decision-making to review the complaint, and if the complaint pertains to clinical matters, licensed, certified or registered healthcare professionals will be involved.

Complaints that can be immediately decided (the same day) to the member's satisfaction will not be responded to in writing. We will document the complaint and decision, and log and track the complaint and decision for quality improvement purposes. If the complaint cannot be decided immediately, we will determine if a complaint is to be expedited or standard.

Expedited complaints may be requested when we determine, or you indicate, that a delay in decision-making could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. A member may also request an expedited review of a complaint.

Expedited and Standard Complaints Time Frames
We must acknowledge the complaint in writing within 15 business days of receipt of the complaint. If a decision is reached before the written acknowledgement is sent, we may include the written acknowledgement with the notice of decision (one notice).

All complaints must be decided as fast as a member's condition requires, but no longer than the following time frames:

- **Expedited:** 48 hours from receipt of all necessary information and no more than seven calendar days from the receipt of the complaint
- **Standard:** 45 calendar days from receipt of all necessary information and no more than 60 calendar days from receipt of the complaint

The member or someone on behalf of the member has the right to file a complaint at any time with the NYSDOH at **800-206-8125**.

Appealing a Complaint Decision
If the member is not satisfied with the decision made concerning a complaint, the member may request a second review of their issue by filing a complaint appeal. The member must file a complaint appeal in writing within 60 business days of receipt of the initial decision. Once the written appeal is received, we establish if the appeal is expedited or standard. You or the member may also request an expedited review of a complaint appeal. The member will receive a written acknowledgement informing them of the name, address, and telephone number of the individual designated to respond to the appeal within 15 business days of receiving their request for appeal. If a decision is reached before the written acknowledgement is sent, the plan may include the written acknowledgement with notice of decision.

All complaint appeals will be conducted by appropriate professionals at a higher level within Anthem than the person who made the complaint determination. Complaint appeal determinations with a clinical basis must be made by personnel qualified to review the appeal, including licensed, certified, or registered healthcare professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer.

For standard appeals, the appeal decision is reached within 30 business days after we receive all necessary information to make the decision, or as fast as the member's condition requires. For expedited complaint appeals, the appeal decision is reached within two business days of receipt of necessary information, or as fast as the member's condition requires. For both standard and expedited complaint appeals, we will provide the member with written notice of the decision. The notice will include the detailed reasons for the decision and, in cases involving clinical matters, the clinical rationale for the decision.

A clinical reviewer other than the clinical reviewer who rendered the adverse determination will review expedited and standard appeals.

Documentation of Complaints and Complaint Appeals

We will maintain a file on each complaint and associated appeal, if any, that will at a minimum include:

- The date the complaint/complaint appeal was filed and a copy of the complaint/complaint appeal
- The date of receipt and a copy of the enrollee's acknowledgement letter, if any, of the complaint/complaint appeal
- All member/provider requests for expedited complaints/complaint appeals and plan decisions about the request
- Necessary documentation to support any extensions (no exceptions on complaint appeals)
- Our determination, including the date of the determination, titles and, in the case of a clinical determination, the credentials of our personnel who reviewed the complaint/complaint appeal

5 ANTHEM HEALTHCARE BENEFITS

Anthem Covered Services

All services and benefits are subject to plan provisions and must be medically necessary. Services other than primary care, obstetrics/gynecology (OB-GYN), mental health/substance use, self-referral and free access services may require precertification. Details about which services require precertification can be found in your *Quick Reference Card* located on our website.

Where applicable, differences between the Medicaid Managed Care and Child Health Plus (CHPlus) covered services are discussed in this section. If no differentiation is made for a particular type of service, the coverage of those services can be considered equal for all of our products.

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

In addition to the full range of medical services, the following benefits are also included:

- Certain specified laboratory procedures performed in the office during the course of treatment (refer to laboratory services)
- Family planning health services including diagnosis, treatment and related counseling furnished under the supervision of a physician (fertility services are not covered)
- Child/Teen Health Plan (C/THP) services, which are comprehensive primary care services provided to children and adolescents under age 19 and behavioral health screening by PCPs for all members as appropriate
- Physical examinations, including those necessary for employment, school, and camp
- Physical and/or mental health or alcohol and substance use examinations as requested by the local Department of Social Services to fulfill its statutory responsibilities for the protection of children and adults and for children in foster care
- Health and mental health assessments for the purpose of making recommendations regarding a recipient's disability status for federal SSI applications
- Physical health and/or mental health or alcohol and substance use assessments for the purpose of making recommendations regarding a recipient's ability to work when requested by a local social services district; Medicaid requires psychosocial assessment to be conducted on each member to include economic, social, psychosocial and emotional problems, as well as domestic violence or sexual assault

Preventive Care
Preventive care means the evaluation and treatment to avert disease/illness and/or its consequences. There are three levels of preventive care: primary, such as immunizations for preventing disease; secondary, such as disease screening programs for early detection of disease; and tertiary, such as physical therapy for restoring function after disease has occurred. An accepted standard of professional/patient care services is required when treating Medicaid Managed Care members.

Prenatal Care Services
Prenatal and obstetrical services may be accessed directly by the member and/or after the PCP confirms a pregnancy and refers the member to a participating obstetrical provider. For Medicaid Managed Care, ongoing risk assessment for both maternal and fetal risk should occur for all pregnant women to include genetic, nutritional, psychosocial, historical, and emergency obstetrical and med-surgical risk factors. Pregnant women are also allowed up to eight smoking cessation counseling sessions within a 12-month period.

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

Free Access Services: Family Planning and Reproductive Health Services
Medicaid Managed Care: Family planning/reproductive services for intrauterine device, sterilization, screening and treatment for sexually transmitted diseases, and HIV pretest counseling with clinical recommendation of testing for all pregnant women are covered by the plan. Members and their newborns must have access to services for positive management of HIV disease, psychosocial support, and case management for medical, social and addictive services. Members may self-refer to access family planning services from an Anthem provider or any provider who accepts Medicaid. Infertility services are not covered.

Emergency Services
Emergency services coverage includes services needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

Emergency medical condition: A physical or behavioral condition, the onset of which is sudden, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following:

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

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

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

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

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

Second Opinion Services
Members may be referred to other providers for second opinions within our provider network, for diagnosis of a condition, treatment, and surgical procedures. Precertification is not required for in-network referrals.

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

Home health coverage also includes two postpartum visits for high-risk infants and mothers, at least one visit to women who stay in the hospital less than 48 hours after birth and at least one visit to women who stay in the hospital less than 96 hours after a cesarean delivery. In each case, the first visit is to occur within 48 hours of discharge.

Child Health Plus Home Healthcare Benefits
Benefits are limited to 40 home healthcare visits per calendar year for services provided by a certified home healthcare agency. The service is covered only if the member would have to be admitted to a hospital or skilled nursing facility if home care was not provided. Four hours of home health aide services equals one visit.

All home health services require prior authorization.

Personal Care Services
Effective May 16, 2022, anyone requesting an initial service of PCS or CDPAS age 18 and above, must be evaluated for services through New York State Independent Process (NYIA). They can be contacted at NYIA Helpline **855-222-8350.**

For members under age 18, follow the process below.

Personal care services (PCS) are covered for members enrolled in the Managed Long-Term Care (MLTC)/Medicaid Advantage Plus (MAP), Temporary Assistance for Needy Families (TANF), HARP

and SSI programs only. For members enrolled in our MLTC/MAP program, please refer to our MLTC/MAP Provider Reference Grid. PCS require precertification and a completed M11Q (physician order). Upon receipt of the M11Q, a UAS field assessor will conduct a home assessment visit to determine the level and type(s) of service(s) needed. The nurse case manager will review the findings from the home assessment and finalize the determination of hours. A notice of determination will be sent to the member and provider and is subject to all applicable appeal rights should the determination differ from the services requested. Interim home-care services may be approved pending determination of PCS based on clinical information provided by the physician.

Consumer Directed Personal Assistance Services (CDPAS)
Effective May 16, 2022, anyone requesting an initial service of PCS or CDPAS age 18 and above, must be evaluated for service through New York State Independent Process (NYIA). They can be contact at NYIA Helpline **855-222-8350**.

For members under age 18, follow the process below.

CDPAS refers to the provision of some or total assistance with personal care services, home health aide services and skilled nursing tasks by a consumer-directed personal assistant under the instruction, supervision and direction of a consumer or the consumer's designated representative.

Consumers are defined as medical assistance recipients (enrollees) who are assessed by the health plan and determined to be eligible to participate in the CDPAS. Upon receipt of the M11Q, a UAS field assessor will conduct a home or telehealth assessment visit to determine the level and type(s) of service(s) needed. The nurse case manager will review the findings from the home assessment and finalize the determination of hours. A notice of determination will be sent to the member and provider and is subject to all applicable appeal rights should the determination differ from the services requested. Interim home-care services may be approved pending determination of PCS based on clinical information provided by the physician and reviewed by the Medical Director.

Personal Emergency Response System (PERS)
PERS is covered when medically necessary and must be made in accordance and coordination with authorization for PCS or home care services.

Behavioral Health Services

Behavioral Health Covered Benefits — Medicaid, HARP, and MAP [1]:
Behavioral healthcare includes mental health and substance use (alcohol) treatment, and rehabilitation services. All of our members have access to services to help with emotional health, or to help with alcohol or other substance use issues. These services include:

[1] Effective as of January 1, 2023, certain Behavioral Health Services are covered for Medicaid Advantage Plus (MAP) members. Please refer to the Anthem Mediblue Health Plus Dual Plus Plan Documents for a Summary of Benefits.

Mental healthcare:

- Day treatment
- Continuing day treatment
- Inpatient mental health treatment
- **Mental Health Outpatient Treatment and Rehabilitative Service:** Assessment, including Health Screening, Psychiatric Assessment Crisis Intervention Services Psychotropic Medication Treatment Injectable Psychotropic Medication Administration (for programs serving adult, Injectable Psychotropic Medication Administration with Monitoring and Education (for programs serving adults) Psychotherapy, including Individual, Group, Family/Collateral Complex Care Management, Peer Support Services Health Monitoring, including Smoking Cessation Health Physical Injectable Psychotropic Medication Administration (for programs serving only children) Injectable Psychotropic Medication Administration with Monitoring and Education (for programs serving only children) Psychiatric Consultation, Testing Services, Developmental Testing, Psychological Testing, Neurobehavioral Status Examination Intensive Outpatient
- Partial hospitalization
- Intensive Outpatient Services
- Personalized recovery oriented services
- Assertive community treatment services
- Individual and group counseling
- **Mental Health Crisis Services**
    - Comprehensive Psychiatric Emergency Program (CPEP) including extended observation bed Crisis intervention services:
    - Mobile Crisis and Telephonic Crisis Services Crisis
      Residential Programs:
    - Residential Crisis Support: This is a program for people who are age 18 or older with symptoms of emotional distress. These symptoms cannot be managed at home or in the community without help.
    - Intensive Crisis Residence: This is a treatment program for people who are age 18 or older who are having severe emotional distress.
- **Other Mental Health Services (members under 21):**
    - These services are covered within CFTSS: Other licensed practitioner, Psychosocial Rehabilitation Services, Community Psychiatric Support & Treatment, Children's Crisis intervention, Family Peer Support Services, Youth Peer Support and Training. These Children HCBS are covered for who are found eligible for HCBS: Caregiver/Family support and education, Community self-advocacy Training and supports, Respite(planned and crisis), Prevocational services, Supported employment, Community Habilitation, Day Habilitation, Additional Benefits for HARP:
        - CORE such as Community Psychiatric Support and Treatment (CPST) Psychosocial Rehabilitation, Peer Support and Family Support and Training.
        - Home and Community Based Services such as Education Support Services, Pre-vocational Services, Transitional Employment, Intensive Supported Employment and On-going Supported Employment.

Substance Use Disorder Services

Crisis services:

- Medically managed withdrawal management
- Medically supervised withdrawal management (inpatient/outpatient*)

Inpatient addiction treatment services (hospital or community based)

Residential addiction treatment services:

- Stabilization in residential setting
- Rehabilitation in residential setting

Outpatient addiction treatment services:

- Intensive outpatient treatment
- Outpatient rehabilitation services
- Outpatient withdrawal management*
- Medication assisted treatment (outpatient drugs for Medicaid and HARP members are covered by Medicaid NYRx)

Opioid Treatment Programs (OTP)

All Medicaid and HARP members can self-refer for mental health and substance use assessment. There are no limits on the number of assessments a member may receive from an in-network provider. These services do not require authorizations or a referral from a PCP. Requests for assessment for children can be sent by the school (with guardian consent), LDSS official, judicial official, probation officer, parent, caregiver or legal guardian, voluntary foster care agency where the agency is assigned care and custody of the child by the LDSS, or similar source.

Emergency/crisis and other services — see details below
Emergency room (ER)
Screening, brief intervention, and referral to treatment (SBIRT) for chemical dependence
CPEP
Mobile crisis services
Health home care coordination and management
Home and community-based services (HCBS) **Note:** HCBS services are a different set of services for HARP versus Children < 21 **Children's HCBS Services: covered as of October 2019:** • Caregiver/family supports and services • Community self-advocacy training and support • Habilitation • Nonmedical transportation[2] • Palliative care • Prevocational services • Respite • Supported employment **Adult HCBS services:** • Education support services • Pre-vocational services • Transitional employment • Intensive supported employment (ISE) • Ongoing supported employment • Nonmedical transportation
CORE **Note:** These services were previously within the HARP HCBS services and are now CORE services and are covered benefits for members who are HARP. **CORE services:** • Psychosocial rehabilitation • Community psychiatric support and treatment habilitation • Empowerment services — peer supports • Family support and training • Nonmedical transportation
CFTSS: Details below: These are covered benefits for members less than 21

[2] Non-Medical Transportation will be paid Fee-for-Service for eligible children/youth, regardless of whether the child/youth is enrolled in Medicaid Managed Care, to leverage the existing Medicaid Fee-for-Service transportation infrastructure.

CFTSS: CPST (community psychiatric supports and treatment)
CFTSS: Family peer support services
CFTSS: Other licensed practitioner (OLP)
CFTSS: Psychosocial rehabilitation (PSR)
CFTSS: Youth peer support and training
CFTSS: children's crisis intervention
Foster Care — Members in foster care are also eligible to receive these additional benefits listed below.
Core limited health related services
Other limited health related services

All members may self-refer for unlimited behavioral health and substance use assessments (except for Assertive Community Treatment [ACT], inpatient psychiatric hospitalization, partial hospitalization, and home- and community-based [HCBS] services). Visits for behavioral health services are coordinated by calling **800-450-8753**. Precertification is not required for behavioral health services when provided by a network provider. Notification is required for many of the covered mental health and substance use services as outlined within the *Quick Reference Guide*. A provider or hospital must be contracted with Anthem to provide these services.

CHPlus Mental Health and Chemical Dependence Benefits
There are no limitations for inpatient or outpatient visits for CHPlus members. Both inpatient and outpatient mental health and substance use services in the CHPlus program are covered without limitations on the level of coverage.

Autism Spectrum Disorder (ASD) Screening, Diagnosis and Treatment
ASDs are pervasive developmental disorders defined in the most recent edition of the diagnostic and statistical manual of mental disorders, including:

- Autistic disorder (also called autism)
- Asperger's disorder (or Asperger's syndrome)
- Rett syndrome
- Childhood disintegrative disorder
- Pervasive developmental disorder
- Related disorders not otherwise specified

CHPlus members diagnosed with an ASD by a licensed physician or psychologist are eligible for:

- Behavioral health treatments
- Psychiatric care
- Psychological care
- Medical care provided by a licensed healthcare provider
- Therapeutic care, even if deemed habilitative or nonrestorative:
    - Covered and may be provided in the member's home, an office, or the community
    - Therapy services delivered in an outpatient setting do not require precertification and have no limitations
- Pharmacy care
- Assistive communication devices:
    - Covered when ordered or prescribed by a licensed physician or psychologist for members unable to communicate through speech or in writing

- Communication boards and speech-generating devices may be rented or purchased and are subject to prior approval
- Dedicated communication devices are not useful to a person in absence of communication impairment; laptops, desktops and tablet computers are not covered items, but the software and/or applications enabling them to function as a speech-generating device are covered under the Durable Medical Equipment benefit; use the Prior Authorization Lookup Tool on our website for specific requirements

Service definitions:

Comprehensive Psychiatric Emergency Program (CPEP)
This licensed, hospital-based psychiatric emergency program establishes a primary entry point to the mental health system for individuals who may be mentally ill to receive emergency observation, evaluation, care, and treatment in a safe and comfortable environment. Emergency visit services include provision of triage and screening, assessment, treatment, stabilization and referral or diversion to an appropriate program. Brief emergency visits require a psychiatric diagnostic examination and may result in further CPEP evaluation or treatment activities, or discharge from the CPEP program. Full emergency visits, which result in a CPEP admission and treatment plan, must include a psychiatric diagnostic examination, psychosocial assessment, and medication examination. Brief and full emergency visit services are reimbursable through Medicaid.

Continued Day Treatment
A continuing day treatment program shall provide active treatment and rehabilitation designed to maintain or enhance current levels of functioning and skills, to maintain community living and to develop self-awareness and self-esteem through the exploration and development of patient strengths and interests.

A continuing day treatment program shall provide the following services: assessment and treatment planning, discharge planning, medication therapy, medication education, case management, health screening and referral, psychiatric rehabilitation readiness development, psychiatric rehabilitation readiness determination and referral and symptom management. The following additional services may also be provided: supportive skills training, activity therapy, verbal therapy, crisis intervention services and clinical support services.

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

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

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

Personalized Recovery Oriented Services (PROS)
PROS is a comprehensive recovery-oriented program for individuals with severe and persistent mental illness. The goal of the program is to integrate treatment, support and rehabilitation in a manner that facilitates the individual's recovery. Goals for individuals in the program are to: improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education and secure preferred housing. A Limited License PROS program provides only ongoing rehabilitation and support and intensive rehabilitative services.

Assertive Community Treatment (ACT) Teams
ACT teams provide mobile intensive treatment and support to people with psychiatric disabilities. The focus is on the improvement of an individual's quality of life in the community and reducing the need for inpatient care by providing person-centered, intense community-based treatment services by an interdisciplinary team of mental health professionals. Building on the successful components of the Intensive Case Management (ICM) program, the ACT program has low staff-outpatient ratios; 24-hour-a-day, seven-day-per-week availability; enrollment of consumers and flexible service dollars. Treatment is focused on individuals who have been unsuccessful in traditional forms of treatment.

Intensive Case Management/Supportive Case Management
Intensive case management (ICM) promotes optimal health and wellness for adults diagnosed with severe mental illness and children diagnosed with severe emotional disorders. Wellness and recovery goals are attained by implementing a person-centered approach to service delivery and ensuring linkages to and coordination of essential community resources. With respect to and affirmation of recipients' personal choices, case managers foster hope where there was little before. Case managers work in partnership with recipients to advance the process of individuals gaining control over their lives and expanding opportunities for engagement in their communities. All case management programs are organized around goals aimed at providing access to services that encourage people to:

- Resolve problems that interfere with their attainment or maintenance of independence or self-sufficiency
- Maintain themselves in the community rather than in an institution

Health Home Care Coordination and Management
Health Home Care Managers provide comprehensive, integrated medical and behavioral healthcare management to Medicaid-enrolled adults with chronic conditions to ensure access to appropriate services, improve health outcomes, prevent hospitalizations and emergency room visits and avoid unnecessary care. HHCM services include person centered recovery focused care plans that may include health promotion; transitional care, including appropriate follow-up from inpatient to other settings; patient and family support; and referral to community and social support services.

Inpatient Hospital Stay to Treat Psychiatric Disorder or SUD Services
A licensed, 24 hr. inpatient treatment program, licensed by the state to offer inpatient treatment.. Includes full-time medical, psychiatric and social services and around-the-clock nursing services for individuals with mental illness.

- **Outpatient SUD services (OASAS BH solo/group practice)**: Outpatient services include participant-centered services consistent with the individual's assessed treatment needs with a rehabilitation and recovery focus designed to promote skills for coping with and managing symptoms and behaviors associated with substance use disorders. These services are designed to help individuals achieve and maintain recovery from SUDs. Services should address an individual's major lifestyle, attitudinal, and behavioral problems that have the potential to undermine the goals of treatment. Outpatient services are delivered on an individual, family or group basis in a wide variety of settings including site-based facility, in the community or in the individual's place of residence:
    - These services may be provided on site or on a mobile basis as defined by the New York State Office of Alcoholism and Substance Abuse Services (OASAS).
- **Opioid treatment program (OPT) – Methadone Maintenance**: OTPs are federally regulated programs that include direct administration of daily medication (opioid agonists: methadone or buprenorphine or antagonists following a successful agonist taper: naltrexone and injectable (Vivitrol) as well as a highly structured psychosocial program that addresses major lifestyle, attitudinal, and behavioral issues that could undermine recovery-oriented goals. The participant does not have a prescription for the methadone or buprenorphine but receives daily medication from the OTP.

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

- **Psychosocial Rehabilitation**: PSR services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their behavioral health condition (in other words, SUD and/or mental health). Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's Recovery Plan. The intent of PSR is to restore the individual's functional level to the fullest possible (in other words, enhancing SUD resilience factors), and as necessary for integration of the individual as an active and productive member of their family.
- **Community Psychiatric Support and Treatment (CPST)**: CPST includes time-limited goal-directed supports and solution-focused interventions intended to achieve identified person-centered goals or objectives as set forth in the individual's Plan of Care and CPST Individual Recovery Plan.

- **Crisis Intervention**: Crisis intervention services are provided as part of a comprehensive specialized psychiatric services program available to all Medicaid-eligible adults with significant functional impairments meeting the need levels in the 1915(i)-like authority resulting from an identified mental health or co-occurring diagnosis. Crisis Intervention services are provided to a person who is experiencing or is at imminent risk of having a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis including a preliminary assessment, immediate crisis resolution and de-escalation. Services will be geared towards preventing the occurrence of similar events in the future and keeping the person as connected as possible with environment/activities. The goals of Crisis Intervention services are engagement, symptom reduction and stabilization. All activities must occur within the context of a potential or actual psychiatric crisis.

Peer Support
Peer Support services are peer-delivered services with a rehabilitation and recovery focus. They are designed to promote skills for coping with and managing behavioral health symptoms while facilitating the utilization of natural resources and the enhancement of recovery-oriented principles (for example, hope, self-efficacy, and community-living skills). Peer support uses trauma-informed, nonclinical assistance to achieve long-term recovery from SUD and mental health issues.

Activities must be intended to achieve the identified goals or objectives as set forth in the participant's individualized recovery plan, which delineates specific goals that are flexibly tailored to the participant and attempt to utilize community and natural supports. The intent of these activities is to assist recipients in initiating, maintaining, and sustaining recovery and enhancing the quality of personal and family life in long-term recovery.

The structured, scheduled activities provided by this service emphasize the opportunity for peers to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. Persons providing these services will do so through the paradigm of the shared personal experience of recovery.

Habilitation and Residential Supports in Community Setting
Habilitation services are typically provided on a 1:1 basis and are designed to assist participants with a behavioral health diagnosis (in other words, SUD or mental health) in acquiring, retaining and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources and the adaptive skills necessary to reside successfully in home and community-based settings.

These services assist participants with developing skills necessary for community living and, if applicable, to continue the process of recovery from a SUD disorder. Services include things such as: instruction in accessing transportation, shopping, and performing other necessary activities of community and civic life including self-advocacy, locating housing, working with landlords and roommates and budgeting. Services are designed to enable the participant to integrate fully into the community and sustain recovery, health, welfare, safety, and maximum independence.

Respite
Temporary services (not beds) provided by trained staff in the consumer's place of residence or other temporary housing arrangement. Includes custodial care for a disabled person so that primary care givers (family or legal guardian) may have relief from care responsibilities. The purpose of respite services is

to provide relief to the primary care provider, allow situations to stabilize and prevent hospitalizations and/or longer term placements out of the home. Maximum respite care services per consumer per year are 14 days. Coverage includes:

- **Short-term Crisis Respite**: Short-term Crisis Respite is a short-term care and intervention strategy for individuals who have a mental health or co-occurring diagnosis, and are experiencing challenges in daily life that create risk for an escalation of symptoms that cannot be managed in the person's home and community environment without onsite supports including:
    - A mental health or co-occurring diagnosis, and the individual is experiencing challenges in daily life that create imminent risk for an escalation of symptoms and/or a loss of adult role functioning but does not pose an imminent risk to the safety of themselves or others.
    - A challenging emotional crisis which the individual is unable to manage without intensive assistance and support.
    - An indication that a person's symptoms are beginning to escalate.
    - Referrals to crisis respite may come from the emergency room, the community, self-referrals, a treatment team or as part of a step-down plan from an inpatient setting. Crisis respite is provided in site-based residential settings and is not intended as a substitute for permanent housing arrangements.
- **Intensive Crisis Respite**: Intensive Crisis Respite (ICR) is a short-term, residential care and clinical intervention strategy for individuals who are facing a behavioral health crisis, including individuals who are suicidal, express homicidal ideation, or have a mental health or co-occurring diagnosis and are experiencing acute escalation of mental health symptoms. In addition, the person must be able to contract for safety.

  Individuals in need of ICR are at imminent risk for loss of functional abilities and may raise safety concerns for themselves and others without this level of care. The immediate goal of ICR is to provide supports to help the individual stabilize and return to previous level of functioning, or to act as a step-down from inpatient hospitalization.

Nonmedical Transportation

Nonmedical transportation services are necessary, as specified by the service plan, to enable participants to gain access to authorized home- and community-based services that enable them to integrate more fully into the community and ensure the health, welfare, and safety of the participant.
This service will be provided to meet the participant's needs as determined by an assessment performed in accordance with NYSDOH requirements and as outlined in the participant's service plan.

Family Support and Training

Training and support necessary to facilitate engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. This service is provided only at the request of the individual. This is a person-centered or person-directed, recovery-oriented, trauma-informed approach to partnering with families and other supporters to provide emotional and informational assistance so that they can support the recovery of a family member with a substance use disorder/mental illness. The individual, their treatment team, and family are all primary members of the recovery team.

For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver and may include a parent, spouse, significant other, children, relatives, foster family, or in-laws. It does not include individuals who are employed to care for the participant.

Training includes instruction about treatment regimens, elements, recovery support options, recovery concepts and medication education specified in the Individual Recovery Plan and shall include updates, as necessary, to safely maintain the participant at home and in the community. All family support and training must be included in the individual's recovery plan and for the benefit of the Medicaid covered participant.

Employment Supports

Prevocational: Prevocational services are time-limited services that prepare a participant for paid or unpaid employment. This service specifically provides learning and work experiences where the individual with mental health and/or disabling substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in competitive work environment as well as in the integrated community settings. Prevocational services occur over a defined period of time and with specific person-centered goals to be developed and achieved, as determined by the individual and their employment specialist and support team.

Prevocational services provide supports to individuals who need ongoing support to learn a new job and/or maintain a job in a competitive work environment or a self-employment arrangement. The outcome of this prevocational activity is to have documentation of the participant's stated career objective and a career plan used to guide individual employment support.

Transitional Employment: This service is designed to strengthen the participant's work record and work skills toward the goal of achieving assisted or unassisted competitive employment at or above the minimum wage paid by the competitive sector employer. This service is provided instead of individual supported employment, only when the person specifically chooses this service. This service may only be provided by a clubhouse, psychosocial club program-certified provider or a recovery center.

This service specifically provides learning and work experiences where the individual with behavioral health and/or substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in the competitive work environment, in integrated community settings paying at or above minimum wage.

The outcome of this activity is to have documentation of the participant's stated career objective and a career plan used to guide individual employment support.

Intensive Supported Employment (ISE): ISE services assist individuals with MH/SUD with obtaining and keeping competitive employment at or above minimum wage. These services consist of individualized, person-centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. This service will follow the evidence-based principles of the Individual Placement and Support (IPS) model.

The IPS model is an evidence-based practice of supported employment. It consists of intensive supports that enable individuals for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their clinical and functional needs, require supports to perform in a regular work setting. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive no less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is to have

documentation of the participant's stated career objective and a career plan used to guide individual employment support.

Ongoing Supported Employment: This service is provided after a participant successfully obtains and becomes oriented to competitive and integrated employment. Ongoing follow-along support is available for an indefinite period, as needed by the participant, to maintain their paid employment position. Individual employment support services are individualized, person-centered services providing supports to participants who need ongoing support to maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving individual employment support services are compensated at or above the minimum wage and receive no less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is to have documentation of the participant's stated career objective and a career plan used to guide individual employment support.

Education Support Services

Education support services are provided to assist individuals with mental health or substance use disorders who want to start or return to school or formal training with a goal of achieving the skills necessary to obtain employment. Education support services consist of special education and related services to the extent to which they are not available under a program funded by IDEA or available for funding by the NYS Adult Career and Continuing Education Services Office of Vocational Rehabilitation (ACCES-VR). Note: The Vocational Rehabilitation component (ACCES-VR) encompasses many of the services that were previously part of Vocational and Educational Services for Individuals with Disabilities, or VESID.

Education support services may consist of general adult educational services such as applying for and attending community college, university, or other college-level courses. Services may also include classes, vocational training and tutoring to receive a Test Assessing Secondary Completion (TASC) diploma, as well as support for the participant to participate in an apprenticeship program.

Participants authorized for education support services must relate to an employment goal or skill development documented in the service plan. Education support services must be specified in the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare, and safety of the participant. Examples of these goals would include, but not be limited to: tutoring or formal classes to obtain a Test Assessing Secondary Completion (TASC) diploma, vocational training, an apprenticeship program or formal classes to improve skills or knowledge in a chosen career, community college, university or any college-level courses or classes.

Ongoing supported education is conducted after a participant is successfully admitted to an educational program. Ongoing follow-along support is available for an indefinite period, as needed by the participant, to maintain their status as a registered student.

Supports for self-directed cares:

- Information and assistance in support of participation direction
- Financial management services

Eye Care and Low-Vision Services: Superior Vision

All professional Optometric and Ophthalmologic benefits are administered through Superior Vision. For a list of Superior Vision participating providers, please contact **800-243-1401** or visit **superiorvision.com**. The vision benefit allows for an exam by a participating optometrist once every 24 months or as medically necessary. Standard eyeglasses may be obtained once every two years or as medically necessary when the optometrist prescribes them for the member. Our members can pay as private customers for nonstandard lenses, which are not covered.

Coverage for contact lenses and low-vision aids are limited to specific medically appropriate conditions. No referral is necessary for optometry visits. A member who is diagnosed with diabetes is eligible for an annual dilated eye (retinal) examination.

Members are financially responsible for upgrades of frames and/or lenses not medically necessary (for example, personal preference upgrades).

Optometry services are also provided by Article 28 clinics affiliated with the College of Optometry of the State University of New York. Enrollees may access optometry services directly without prior approval and without regard to network participation.

CHPlus Eye Care and Low-Vision Services
The CHPlus vision benefit is as described above, except vision examinations and eyeglasses are covered every 12 months. Eyeglasses may be obtained once every 24 months unless otherwise justified as medically necessary.

Hearing Services

Hearing evaluations, diagnostic tests, and selective amplification procedures necessary to certify an individual for a hearing aid device, hearing aids and repair services are included. Hearing aid services are available by PCP referral to participating providers. Hearing aid batteries are also included as part of this benefit.

Ambulatory Rehabilitation Therapies

Physical, occupational and speech therapy are covered for the reduction of disability and the restoration of best functional level. Precertification is required for these services from Carelon Medical Benefits Management. Limitations apply based on line of business. Refer to "Therapy" under the *Other Covered Services* section below.

Durable Medical Equipment, Prosthetics/Orthotics

Durable medical equipment (DME) is defined as devices and equipment in the home (other than medical/surgical supplies, enteral formula, and prosthetic or orthotic appliances) for repeated use for the purpose of aiding in treating illness and improving the function of a body part:

- DME and rehabilitative equipment require precertification.
- For Medicaid and HARP members, coverage includes items listed in sections 4.4, 4.5, 4.6, and 4.7 of the NYS Fee-for-Service **Durable Medical Equipment, Prosthetics, Orthotics, Supplies and Procedure Codes and Coverage Guidelines**. DME supplies within sections 4.1, 4.2, and

4.3 when billed by a medical institution or provider office will remain the responsibility of the MCP.

- For CHPlus members, coverage includes all items listed on the NYS Fee Schedule.
- Coverage includes equipment servicing but excludes disposable medical supplies.
- DME is not indicated in the absence of illness or injury.
- Orthotic devices are those which are used to support a weak or deformed body or to restrict or eliminate motion in a diseased or injured part of the body.
- Prosthetic appliances are those appliances and devices ordered by a qualified practitioner which replace any missing part of the body.
- This benefit also includes software or computer applications, allowing devices to generate speech for CHP members diagnosed with ASDs; it does not cover the devices (for example, laptops, tablets, or desktop computers) themselves.

Enteral Formula and Nutritional Supplements

Enteral formula and nutritional supplements are covered for Child Health Plus members:

- Children who have metabolic or absorption disorders
- Children who require medical formulas due to mitigating factors in growth and development
- Individuals who have rare, inborn metabolic disorders
- Tube-fed individuals who cannot chew or swallow

Enteral formula and nutrition supplements will only be covered under the DME benefit and must be obtained through a DME provider rather than a pharmacy for Child Health Plus members. Enteral Formula and nutritional supplements for Medicaid and HARP members located in Sections 4.1, 4.2 and 4.3 of the New York State Medicaid 2023 Provider Manual are included in the NYRx transition. After April 1, 2023, claims for MMC members for items in these sections will be reimbursed through NYRx or DMEPOS FFS providers and billed directly to Medicaid. All prior approval/authorization systems or procedures are in effect as for current FFS members.

Laboratory, Diagnostic, and Radiology Services

Only participating laboratories and radiology services may be authorized by the PCP. A referral form is required. Participating laboratory testing sites providing services must have a permit issued by the NYSDOH *and* a Clinical Laboratory Improvement Act (CLIA) identification number in addition to one of the following: a CLIA certificate of waiver, a Physician-Performed Microscopy Procedures (PPMP) certificate or a certificate of registration. Those laboratories with certificates of waiver or a PPMP certificate may perform only those specific tests permitted under the terms of the waiver. Laboratories with certificates of registration may perform a full range of laboratory tests for which they have been certified. Physicians providing laboratory testing may perform only those specific limited laboratory procedures identified in the Physician's Medicaid Management Information Systems (MMIS) manual. Radiology services include the provision of diagnostic radiology, diagnostic ultrasound, nuclear medicine, radiation oncology and MRI. These services may only be performed upon the order of a qualified medical professional, including dentists. Refer to the *Quick Reference Card*, as these services may require precertification and clinical review. Note: Mammograms do not require precertification.

Podiatry Services

Services include routine foot care when the enrollee'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.

Private Duty Nursing Services

Private duty nursing services must be provided in the home and are covered only if authorized as medically necessary by the PCP and upon precertification from us. Private duty nursing is a noncovered benefit for CHP members.

Dental Services — LIBERTY Dental Plan

Dental care for members will be handled through LIBERTY Dental Plan. LIBERTY will assign your patient to a primary care dentist who will be responsible for all of their general dental needs. This includes checkups, cleanings, routine fillings, extractions, and referrals for necessary specialty care. Dental procedures requiring anesthesia and/or planned inpatient admissions or services at an outpatient ambulatory center must first be approved by LIBERTY. Upon completion of treatment, all facility and anesthesia charges must be billed separately to us. For benefit information, contact the LIBERTY Provider Hotline at **888-352-7924**.

Emergent and Nonemergent Transportation: Medical Answering Services, LLC

In an emergency, members are instructed to call **911**. Emergency transportation by air or ambulance is covered without precertification for all members. Planned air transportation (airplane or helicopter) requires precertification.

We and the state of New York partner with Medical Answering Services, LLC, to coordinate nonemergency transportation appointments and provide routine transportation to our members in New York state. Contact Medical Answering Services regarding transportation needs for our members in your care. Members can work directly with Medical Answering Services to ensure they fulfill their scheduled, nonemergent appointments.

Medicaid Managed Care

- **New York City:** Nonemergency transportation for members in New York City is provided by Medical Answering Services and covered by regular Medicaid. To arrange nonemergency transportation for a member, you or the member should call Medical Answering Services at **844-666-6270**. If possible, call Medical Answering Services at least **three days** before the medical appointment and provide:
    - Member's Medicaid identification number (in other words, AB12345C)
    - Member's appointment date and time
    - Name and address of the provider the member is seeing
- **Putnam County:** Members in Putnam County can call, or ask their provider to call, Medical Answering Services (MAS) at **800-850-5340** to arrange nonemergency or routine

transportation. If possible, call MAS at least **three days** before the medical appointment and give them the following information:
    - Member's Medicaid ID card number
    - Member's appointment date and time
    - Name and address of the doctor the member is seeing
- **Nassau County:** We cover nonemergency transportation for members in Nassau County. Services are provided by Modivcare. Members and providers should call **800-850-5340** to arrange services. If you distribute passes directly to eligible members, you can request a replenishment of/reimbursement for those passes from Modivcare.

The enrollee may have to pay for any service that includes:
- Noncovered services.
- Unauthorized services.
- Services provided by nonparticipating providers.

MLTC/MAP
We cover nonemergency transportation for MLTC/MAP members. Services are provided by ModivCare. Members and providers should call **866-481-9667** to arrange services. If you distribute passes directly to eligible members, you can request a replenishment of/reimbursement for those passes from ModivCare.

Pharmacy Services

Beginning April 1, 2023, the pharmacy benefit for Medicaid Managed Care and HARP members transitioned to NYRx, the Medicaid pharmacy program. Anthem covers pharmacy benefit for Child Health Plus members.

Our pharmacy benefit covers medically necessary medications from licensed prescribers for the purpose of maintaining members' whole health, including saving lives in emergency situations or during short-term illness, sustaining life in chronic or long-term illness, or limiting the need for hospitalization. Please note certain medications require prior authorization. Our members have access to most national pharmacy chains and many independent retail pharmacies. Our pharmacy network consists of over 2,000 pharmacies in the five boroughs of New York City and includes the major chains like CVS pharmacy, Rite Aid and ShopRite, as well as most independently owned pharmacies. Members must use an Anthem network pharmacy when filling prescriptions in order for benefits to be covered. For specialty drugs, please refer to the Specialty Drug Program section below.

Monthly Limits
Most prescriptions are limited to a maximum 30-day supply per fill at a retail pharmacy (with the exception of contraceptives and asthma controllers).

Covered Drugs
Our CHP pharmacy program uses a *Preferred Drug List* (*PDL*), a list of preferred drugs within the most commonly prescribed therapeutic categories. The *PDL* is comprised of drug products reviewed and approved by our Pharmacy and Therapeutics (P&T) Committee. The P&T Committee is comprised of network physicians, pharmacists and other healthcare professionals who evaluate safety, efficacy, adverse effects, outcomes, and total pharmacoeconomic value for each drug product reviewed.

The *CHPlus PDL* is posted on our provider self-service site. For a hard copy, contact the Pharmacy department at **800-450-8753**. Please use *Pharmacy Hot Tips* on our website to easily identify preferred products for common therapeutic categories.

The following are examples of the covered items:

- Legend drugs
- Insulin
- Disposable insulin needles/syringes
- Lancets and lancet devices
- Compounded medication of which at least one ingredient is a legend drug and listed on the *Anthem CHPlus PDL*
- Any other drug which, under the applicable state law, may only be dispensed upon the written prescription of a physician or other lawful prescriber and is listed on the *Anthem CHPlus PDL*

Over-the-Counter (OTC) Drugs

Most over-the-counter (OTC) medications listed in the NYS Fee-for-Service Medicaid formulary are included in the *CHPlus PDL* and are covered if prescribed by a physician (exceptions may apply). The list is subject to change. The following are examples of OTC medication classes covered:

- Analgesics/antipyretics
- Antacids
- Antibacterials, topical
- Antidiarrheals
- Antiemetics
- Antifungals
- Antihistamines
- Contraceptives
- Cough and cold preparations
- Decongestants
- Diabetic supplies, needles, and syringes
- Laxatives
- Non-steroidal anti-inflammatory agents
- Pediculocides
- Prenatal vitamins
- Respiratory agents (including spacing devices)
- Topical anti-inflammatories
- Topical pain medication

Branded versus Generic Drugs

Our pharmacy program is a mandatory generic program for brand products where there is a generic equivalent. Brand name medications, if medically necessary, can be requested through the PA process. Select narrow therapeutic index medications are excluded from the mandatory generic program.

Contraceptives

The pharmacy benefit covers prescription and OTC contraceptives. The member may receive up to a 12-month supply in a single fill for maintenance contraceptives. Intrauterine devices are covered under medical benefits and not covered as pharmacy claims.

Infertility Drugs
Infertility drugs are not a covered benefit for CHPlus.

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

PA may be requested by submitting an electronic PA through **covermymeds.com** or through Surescripts.

PA may also be submitted for CHPlus by calling Provider Services at **800-450-8753**. Be prepared to provide relevant clinical information regarding the member's need for a nonpreferred product or a medication requiring PA. Decisions are based on medical necessity and are determined in accordance to certain established medical criteria.

A Prior Authorization form for Anthem members can also be found on our website at **https://providers.anthem.com/ny** > Resources > Forms and can be submitted by fax. Be prepared to submit relevant clinical information regarding the member's need for a nonpreferred product or a medication requiring PA along with the fax form.

For Pharmacy PAs for Medicaid and HARP members, please contact NYRx at **877-309-9493**. A *Prior Authorization Form* can also be found at **newyork.fhsc.com/providers/pa_forms.asp**.

PA review time frames
PA requests for CHPlus are reviewed and notification of a decision is made within 24 hours of receipt of a completed request through both verbal and written correspondence.

To ensure timely processing of requests, all relevant clinical information and previous drug history must be included and/or provided with the request.

Emergency supply
Anthem network pharmacies may provide a 72-hour emergency supply of medication to members who have an immediate need to start a medication that is being reviewed for coverage through the PA process. The network pharmacy may enter the designated override code CarelonRx provides and submits a claim for the 72-hour supply of medication. You don't need to call to request the emergency supply. Exclusions may apply.

Excluded Drugs
The following drugs are examples of medications that are **excluded** from the pharmacy benefit:

- Anti-wrinkle agents (for example, Renova)
- Compound bulk powder
- Drugs used for cosmetic reasons or hair growth
- Drugs used for experimental or investigational indication
- Growth hormones used for idiopathic short stature (ISS)
- Infertility medications — except bromocriptine, clomiphene, letrozole, tamoxifen
- Non-CMS rebatable drugs

- DESI 5 or 6 drugs
- Sexual dysfunction drugs (for example, Viagra and Intrarosa)
- Weight-loss drugs

Drugs not covered by pharmacy benefit but available under the medical benefit:

- Enteral formula
- Gene therapy
- Hemophiliacs
- Implantable drugs and devices (for example, Mirena, Paragard) (see "Intrauterine Devices" section)

Hyaluronic drugs are not covered by pharmacy or medical benefit for any indication (for example):

- J7321 — Hyalgan or Supartz
- J7323 — Euflexxa
- J7324 — Orthovisc
- J7325 — Synvisc or Synvisc-one
- J7326 — Gel-One

Specialty Drug Program

Anthem CHPlus members have the option to fill their specialty medication at our preferred specialty pharmacy, CarelonRx, Inc. or other pharmacies in our specialty network. The list of approved specialty pharmacy providers is subject to change.

Specialty medications are drugs that treat complex or chronic conditions, generally requiring close supervision or monitoring of therapy, and often requiring special storage.

CarelonRx Specialty pharmacies have highly trained pharmacists and nurses to provide personal care and guidance to help members manage their condition. With CarelonRx Specialty Pharmacy, members get:

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

To schedule delivery for specialty medications from our preferred specialty pharmacy, members can contact CarelonRx at **833-255-0646**.

The list of approved specialty pharmacy providers is subject to changes.

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

Prenatal Vitamins

Anthem's CHPlus formulary contains an extensive list of prenatal vitamins, including Atabex, Nestab tablet, Obtrex tablet, One-A-Day Women's Prenatal, Right Step Prenatal, Theranatal Core Nutrition, and many other OTC formulations.

Intrauterine Devices
Please use the options below to receive long-acting reversible contraceptives for administration at your office. These devices can only be obtained under the medical benefit using the below instructions. As always, you have the buy and bill option under a member's medical benefit.

For Kyleena, Mirena, Liletta, and Skyla: If you choose CVS/Caremark Specialty Pharmacy under the medical benefit, they are available to assist you Monday through Friday from 7:30 a.m. to 7:30 p.m. ET and can accept the prescription using a method convenient for you. The prescription can be given to a CVS Specialty pharmacist over the phone by providing the patient's name and insurance information at **877-254-0015**. The prescription or the completed manufacturer form can also be faxed to **866-336-8479**. The buy and bill option under the member's medical benefit is also an option.

For Nexplanon: You must first follow the manufacturer's instructions by calling **844-NEX-4321** (**844-639-4321**) Monday through Friday from 8 a.m. to 8 p.m. ET or online at **merckconnect.com/nexplanon/ordering-billing.html**. After this, you have the option of CVS/Caremark Specialty Pharmacy or buy and bill, both under the medical benefit.

For Paragard: Use the buy and bill option. Call Paragard Access Solutions at **877-PARAGARD** (**877-727-2427**). They are available Monday through Friday from 8:30 a.m. to 8 p.m. ET or online at **paragardaccesssolutions.com**. Use the Paragard Direct option for providers.

Opioids
Per New York state regulations, prescriber may not initially prescribe more than a 7-day supply of an opioid medication for acute pain. This rule does not include prescribing for chronic pain, pain being treated as a part of cancer care, hospice or other end-of-life care, or palliative care. Upon any subsequent consultations for the same pain, the practitioner may issue, in accordance with existing rules and regulations, any appropriate renewal, refill, or new prescription for an opioid.

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

Members will be limited to four prescriptions for Opioids in a rolling 30 calendar day period. Prior Authorization maybe required for these patients to fill more than four opioid prescriptions in a 30-day period if system configuration does not allow their claims to bypass. Exceptions are given to patients being treated for cancer, sickle cell anemia and long term care pharmacy claims.

Smoking Cessation Products
Some smoking cessation products are covered without prior authorization or course limitation. However, quantity limit, refill-too-soon edit, and age limit (if applicable) still apply.

Split Fill Program
The split fill program is designed to prevent wasted prescription drugs if the treatment plan changes. The prescription drugs included under this program have been identified as requiring more frequent follow up to monitor response to treatment and reactions.

The initial and/or the second prescription are limited to a 15-day supply. The therapeutic classes included in this program are (list is subject to change):

- Anti-neoplastic agents
- Hepatitis B agents
- Certain antipsychotics

The initial and/or the second prescription are limited to a small-sized tube. The therapeutic class included in this program is (list is subject to change):

- Topical acne treatment

Vaccines

Anthem covers influenza and pneumococcal vaccines under the CHPlus pharmacy benefit. In the state of New York, pharmacists are allowed to administer influenza vaccines to children as young as 2 years old. Coverage of the cost of vaccine for children thru 18 years of age continues to be provided through the Vaccine for Children (VFC) program.

Participating VFC pharmacies can submit the administration fee of the influenza vaccine via NCPDP D.0 claims. The cost of the flu vaccine is covered by the VFC program and shall not be charged to Anthem. However, pharmacist administration fee is reimbursable when submitted in the ingredient cost field.

Anthem covers COVID-19 vaccines.

Medical Injectables (Physician Administered Drugs)

For Medicaid, HARP, and CHPlus certain medical injectables obtained directly by a medical provider or infusion pharmacy, and administered in a medical setting may require pre-certification. To determine whether the medical injectable you are prescribing requires pre-certification, please refer to the Prior Authorization Lookup Tool at **https://providers.anthem.com/ny** > Claims > Prior Authorization Lookup Tool.

PA may be requested by submitting a digital PA through Availity Essentials. From Availity's home page, select **Patient Registration**, then **Authorizations & Referrals** and follow the steps.

PA may also be submitted by calling Provider Services at **800-450-8753**. Be prepared to provide relevant clinical information regarding the member's need for a nonpreferred product or a medication requiring PA. Decisions are based on medical necessity and are determined in accordance with certain established medical criteria.

A Prior Authorization form for Anthem members can also be found on our website at **https://providers.anthem.com/ny** > Resources > Forms and can be submitted by fax. Be prepared to submit relevant clinical information regarding the member's need for a nonpreferred product or a medication requiring PA along with the fax form.

Pharmacy Clinical Programs

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

- HEDIS measures

- Controlled substance utilization monitoring
- Asthma management
- Diabetes management
- Depression/Psychosis management
- Polypharmacy

Certain programs may request response from our providers. If you have any questions regarding the letter/fax you received, please contact the phone number listed on the letter/fax.

Other Practitioners

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

Other Covered Services

Vaccines for Children Program
The New York State Department of Health requires physicians and other providers to obtain all vaccines for their Medicaid and Child Health Plus patients through the Vaccines for Children (VFC) program. Providers who are not enrolled in VFC must enroll in order to receive vaccines. Providers who do not participate in the VFC program will not receive free vaccines, nor will they receive payment from Anthem for the cost of the vaccine. Medicaid and Child Health Plus members cannot be billed for vaccine costs.

For information about VFC enrollment in NYC, contact the VFC program at **212-447-8175** Monday through Friday from 9 a.m. to 5 p.m. For information about VFC enrollment in all other locations, contact the New York State VFC program at **800-KID SHOTS (800-543-7468)** Monday through Friday from 9 a.m. to 5 p.m. More information on VFC can also be found at: **health.ny.gov/prevention/immunization/vaccines_for_children**.

Therapy
Occupational, physical, and speech rehabilitation services rendered for the purpose of maximum reduction of physical or mental disability and restoration of the member to their best functional level are covered. Rehabilitation services include care and services rendered by occupational therapists, physical therapists, and speech-language pathologists. Precertification is required for outpatient therapy services.

Medicaid Managed Care members: Limits do not apply to outpatient visits for physical, occupational, and speech therapy. Visits are based on medical necessity for PT, OT, and ST

CHP: 40 visits per calendar year combined with OT (total between PT and OT cannot exceed 40 visits). Speech therapy has no benefit limits but is based on medical necessity.

Midwife Services
These services apply to the healthcare management of mothers and newborns throughout the maternity cycle (normal pregnancy, childbirth, and the immediate postpartum period of six weeks), and to primary preventive reproductive healthcare as specified in a written practice agreement, including newborn evaluation, resuscitation, and referral for infants. Prenatal and postpartum care may be provided in a hospital on an inpatient basis or outpatient basis, in a diagnostic and treatment center, in the office of the midwife or collaborating physician or in the member's home, as appropriate. Deliveries must take place in a hospital setting. The certified nurse midwife must be licensed in accordance with the current NYS rules and regulations governing a midwifery practice.

Refer to your individual contract for further details on covered services related to capitation or inclusive agreements.

Hearing Aid Services
Hearing aid devices furnished to alleviate disability caused by the loss or impairment of hearing.

Court-ordered Services
We will provide any benefit package services to members as ordered by a court of competent jurisdiction, regardless of whether such services are provided by participating providers within the plan or by a nonparticipating provider in compliance with such court order. We will reimburse the nonparticipating provider at the Medicaid fee schedule. We're responsible for court-ordered services to the extent that such court-ordered services are covered by and reimbursable by Medicaid.

Federally Qualified Health Center Services
Services provided by a Federally Qualified Health Center (FQHC) provided in accordance with care delivery policies and coverage as outlined in this manual.

Prescription Footwear
The prescription footwear benefit covers the following:

- Orthopedic footwear required by children under 21
- Shoes attached to a lower-limb orthotic brace
- Footwear that is a component of a comprehensive diabetic treatment plan to treat amputation, ulcerations, preulcerative calluses, peripheral neuropathy with evidence of callous formation, foot deformities, or poor circulation

Compression Stockings
Specific gradient compression stockings are covered when prescribed:

- As treatment for open venous ulcers
- For pregnant members

Smoking Cessation Counseling (SCC)
SCC is now a covered benefit for all enrollees who smoke. Each Medicaid Managed Care member is allowed eight counseling sessions per calendar year, which must be provided on a face-to-face basis. SCC complements the use of prescription and nonprescription smoking cessation products. These products are also covered by Medicaid.

Noncovered Services

This noncovered services section is not applicable to MLTC/MAP members. For members enrolled in our MLTC/MAP program, please refer to our *MLTC/MAP Provider Reference Guide* for noncovered services and benefits information. To verify if a service is covered, call Provider Services. The following services are not covered, but are coordinated with the MLTC/MAP member:

- Emergency room services
- Provider Services (including services provided in an office setting, clinic, a facility or in the home)
- Inpatient hospital services
- Outpatient hospital services
- Laboratory services
- Radiology and radioisotope services
- Prescription and nonprescription drugs
- Emergency transportation
- Rural health clinic services
- Chronic renal dialysis
- Alcohol/substance use services
- Family planning services
- Certain noncovered behavioral health services
- Certain noncovered mental health services
- Certain rehabilitation services provided to residents of the Office of Mental Health licensed community residences and family-based treatment programs
- Office for People with Developmental Disabilities services
- Preschool supportive health services
- School supportive health services

Effective October 1, 2019, some infertility services are covered by Anthem.

Note: The coverage of any experimental procedures or experimental medications is determined on a case-by-case basis.

New Baby, New Life℠ Program

New Baby, New Life℠ is a proactive care management program for all expectant members and their newborns. We use several resources to identify pregnancies as early as possible. Sources of identification include, state enrollment files, claims data, and hospital census reports as well as provider

and member self-referrals. Once pregnant members are identified, we act quickly to assess obstetrical risk and ensure appropriate levels of care management services to mitigate risk.

Experienced case managers work with members and providers to establish a care plan for our highest risk pregnant members. They may also collaborate with community partners to facilitate connecting members to local and national agencies who can assist with services and support.

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

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

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

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

Anthem requires notification of pregnancy at the first prenatal visit and notification of delivery following birth. You may choose to complete the notification of pregnancy and delivery in Availity Essentials or fax the forms to **800-964-3627**. You can also arrange to notify the health plan directly on a weekly basis. Ask your Provider Relationship Management representative how to get started.

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

For more information about the New Baby, New Life program or the digital maternity program, reach out to your OB Practice Consultant or Provider Services at **800-450-8753** or refer to our website at **https://providers.anthem.com/new-york-provider/patient-care/pregnancy-and-maternal-child-services.**

Newborn intensive care unit (NICU) care management

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

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

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

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

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

Blood Lead Screening

Providers will furnish a screening program for the presence of lead toxicity in pregnant women and children that consists of a screening and blood test. During every well-child visit for children between the ages of 6 months and 6 years old, the PCP will screen each child for lead poisoning. A blood test will be performed at 12 months and 24 months of age to determine lead exposure and toxicity. In addition, children over the age of 24 months up to 72 months should receive a blood lead screening if there is not a past record of a test. Individual and group private practices must be certified as Physician Office Laboratories (POLs); facilities must be registered as Limited Services Laboratories (LSLs) to be authorized to conduct blood lead testing onsite and receive reimbursement. LSLs and POLs must bill the health plan for in-office lead testing using CPT-4 procedure code 83655. Reimbursement will be in accordance with agreements between the provider and the health plan. Please see blood lead risk forms located in *Appendix A — Forms*.

Outpatient Laboratory and Radiology Services

All outpatient laboratory tests except for CLIA-approved office tests should be performed at a network facility outpatient lab or at one of the Anthem preferred network labs (LabCorp or Quest Diagnostics). Visit the CMS website at **cms.hhs.gov** for a complete list of approved accreditation organizations under CLIA.

Self-Referral Services

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

- Emergency care (regardless of network status with Anthem)

- Family planning (Medicaid Managed Care members have free access to either network or non-network FFS providers. CHPlus members have direct access to network providers)
- Behavioral health assessments (nonparticipating providers must seek prior approval from Anthem)
- OB care (nonparticipating providers must seek prior approval from Anthem)
- Well-woman/GYN care (nonparticipating providers must seek prior approval from Anthem)
- EPSDT/well-child (nonparticipating providers must seek prior approval from Anthem)
- Tuberculosis, STD, HIV/AIDS testing and counseling services (regardless of network status with Anthem)
- Unlimited behavioral health and substance use assessments (except for Assertive Community Treatment [ACT], inpatient psychiatric hospitalization, partial hospitalization and HCBS services)

Restricted Recipient Program

Anthem and the other MCOs in New York are responsible for managing members in the state's Restricted Recipient Program (RRP) for enrollees who may be misusing the health system and who may benefit from receiving focused supports from their PCP and a single pharmacy.

These members will have one or more of the following restrictions in place:

- Primary medical provider (this can be a physician, physician group, or clinic)
- Primary hospital provider
- Primary dental provider (may be a dental clinic or a dentist)
- Primary DME provider
- Primary podiatrist (rarely used)

What is a Restricted Recipient?
Enrollees are identified as restricted recipients (RRs) if they have demonstrated a pattern of abusing or misusing covered services.. RRs may be enrolled in TANF, SSI and within a New York Medicaid program. Enrollees may be restricted to one or more RRP providers for receipt of medically necessary services included in the benefit package.

For example, if an RR has excessive visits with multiple primary care providers, the RR will be assigned to one primary care provider for a determined time frame. **A member may have more than one restriction.**

Restricted Recipients and Continuity of Care
We will manage the member's restriction. Anthem restricts the member to the PCP or provider and duration of the restriction.

For members receiving services from nonparticipating providers, Anthem will authorize continued visits for the 60-day provision. Members will then be transitioned and restricted to an in-network provider.

Members will have access to providers outside the specific provider restriction type. The member's PCP will manage their care and provide referrals as appropriate. A referral is required from their PCP unless

the service was provided in an emergency, was a methadone maintenance claim or a service provided in an inpatient setting.

Please note: Restrictions can be placed by an MCO such as Anthem or the Office of the Medicaid Inspector General; therefore, Anthem providers must check EPACES prior to rendering services to verify eligibility and identify any restriction a member may have.

Member Rights and Responsibilities

Members have rights and responsibilities when participating with an MCO. Our Member Services representatives serve as advocates for Anthem members. The following lists the rights and responsibilities of members.

Members have the right to:

- Be cared for with respect, without regard for health status, gender, gender identity, race, color, religion, national origin, age, marital status, or sexual orientation. If you have any questions or concerns about this right, call **800-300-8181** and ask for extension **34925** or visit **https://providers.anthem.com/ny**.
- Be told where, when, and how to get the services they need from Anthem.
- Be told by their PCP what is wrong, what can be done for them, and what will likely be the result, in a language they understand.
- Get a second opinion about their care.
- Give their approval to any treatment or plan for their care after that plan has been fully explained to them.
- Refuse care and be told what the risks are if they refuse care.
- Get a copy of their medical records, talk about it with their PCP, and ask that their medical record be amended or corrected, if needed.
- Be sure that their medical records are private and will not be shared with anyone except as required by law, contract or with their approval.
- Get a copy of the Notice of Privacy Practices that explains patient rights on Protected Health Information (PHI) and the responsibility of Anthem to protect PHI. This includes the right to know how Anthem handles, uses, and gives out PHI:
    - PHI is defined by *HIPAA Privacy Regulations* as information that:
        - Identifies a member or can be used to identify a member.
        - Comes from a member or has been created or received by a healthcare provider, a health plan, an employer, or a healthcare clearinghouse.
        - Has to do with a physical or mental health condition, providing healthcare to a member, or paying for providing healthcare to a member.
- Use the Anthem complaint and appeal system to settle any complaints and appeals, or to complain to the NYSDOH or the local Department of Social Services anytime a member feels they have not been treated fairly or about the organization or care it provides.
- Use the state fair hearing system (except for CHPlus members).
- File an action appeal as a result of Anthem denying a service authorization request from a member or their doctor.
- Appoint someone (relative, friend, lawyer, etc.) to speak for them if they are unable to speak for themselves about their care and treatment or if they simply want someone else to speak for them.

- Have access to a PCP or a backup PCP 24 hours a day, 365 days a year for urgent care; this information is on their Anthem member ID card.
- Choose a PCP, choose a new PCP, and have privacy during a visit with a healthcare provider.
- Be referred to a non-network provider if Anthem does not have an appropriately trained provider in our network.
- Receive needed medical services within a reasonable amount of time.
- Take part in making decisions about their healthcare with their healthcare provider.
- Receive information and discussion on available treatment options and alternatives, regardless of cost or benefit coverage.
- Receive considerate, respectful care in a clean, safe environment free of unnecessary restraints.
- Choose any of our Anthem network specialists after getting a referral from their PCP.
- Be referred to specialists who are experienced in treating disabilities, if needed.
- Receive information about Anthem, its services, policies and procedures, providers, member rights and responsibilities, and any changes made.
- Know about all benefits and medical services available from Anthem.
- Request information about the plan, including clinical review criteria used by the plan in a utilization review decision on a specific disease or condition, upon request.
- Get a current directory of providers within the Anthem network, upon request.
- Know how Anthem pays providers, so members know if there are financial incentives or disincentives tied to medical decisions.
- Decide ahead of time the kind of care they want if they become sick, injured, or seriously ill by making a living will.
- If members are younger than age 18, expect that they will be able to participate in and make decisions about their own and their child's healthcare if they are married.
- Continue as members of Anthem despite their health status or need for care.
- Call our 24/7 NurseLine toll free at **800-300-8181**.
- Call our Member Services department toll free at **800-300-8181** from 8 a.m. to 8 p.m. Monday through Friday, and 9 a.m. to 5 p.m. on Saturdays (except for state holidays).
- Discuss questions they may have about their medical care or services with Anthem by calling Member Services at **800-300-8181**.
- Get help from someone who speaks their language.
- Make suggestions about the Anthem member rights and responsibilities policy.

Members have the responsibility to:

- Learn about how their healthcare plans work.
- Carry their Anthem ID cards at all times; members should report any lost or stolen cards to Anthem immediately and should contact Anthem if card information is wrong or if their name, address, or marital status changes.
- Show their ID cards to providers and tell Anthem about any providers they are currently seeing.
- Work with their PCPs to guard and improve their health.
- Give Anthem and their PCPs the information they need to take care of their medical needs.
- Listen to advice from their PCPs and ask questions when they are in doubt.
- Know and get involved in their healthcare; members should talk with their PCPs about recommended treatment and follow the plans and instructions for care agreed upon, to the best of their ability.
- Get information and understand their health problems and consider treatments so they can participate in developing mutually agreed upon treatment goals before services are performed.

- Call or go back to their PCPs if they do not get better or ask for a second opinion.
- Treat healthcare staff with the same respect the member expects.
- Tell Anthem if they have problems with any healthcare staff by calling Member Services.
- Keep their appointments; if they must cancel, call as soon as they can.
- Only use emergency rooms for true emergencies.
- Receive their covered, nonemergency medical services from Anthem providers.
- Call their PCPs when they need medical care, even if it is after office hours.
- Get PCP referrals before they go to or take their children to a hospital or a specialist (except for emergencies and self-referral services).
- Know how to take their medicines the right way.
- Be responsible for copays as described in their member handbook.
- Be aware that refusing the treatment suggested by their providers may have serious consequences for their health or the health of their children.
- Inform their PCPs about their health or the health of their children.
- Authorize PCPs to get copies of their medical records and those of their children.
- Learn about and follow Anthem health plan membership rules.
- Clearly state their complaints or concerns.

First Line of Defense Against Fraud

Healthcare fraud costs taxpayers increasingly more money every year. There are state and federal laws designed to crack down on these crimes and impose strict penalties. Fraud, waste, and abuse in the healthcare industry may be perpetuated by every party involved in the healthcare process. There are several stages to inhibiting fraudulent acts, including detection, prevention, investigation, and reporting. In this section, we educate providers on how to help prevent member and provider fraud by identifying the different types, so you can be the first line of defense.

We are committed to protecting the integrity of our healthcare program and the effectiveness of our operations by preventing, detecting, and investigating fraud, waste, and abuse. Combating fraud, waste, and abuse begins with knowledge and awareness.

- **Fraud** — Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it — or any other person. It 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 unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- **Abuse** — Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to benefit programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare; it also includes beneficiary practices that result in unnecessary cost to the benefit program.

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

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

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* (*EOBs*) for any errors and then contact member services if something is incorrect.

What can you do to help prevent fraud, waste, and abuse?

- Carefully review each member's Anthem member ID card to ensure the cardholder is the person named on the card; this is the first line of defense against fraud.
  (Note: Anthem may not accept responsibility for the costs incurred by providers rendering services to a patient who is not a member, even if that patient presents an Anthem member ID card.)
- Educate members about the types of fraud and the penalties levied.
- Spend time with patients and review their records for prescription administration.
- Encourage members to protect their cards as they would a credit card or cash, to carry their Anthem member ID card at all times, and to report any lost or stolen cards to Anthem as soon as possible.

Reporting Critical Incidents

As an Anthem provider and a participant in government-sponsored healthcare, you and your staff are obligated to report suspected fraud, waste, and abuse. We encourage our members and providers to report suspected instances by:

- Anonymously submitting a report via our fraud education site: ***Fraud, Waste and Abuse form*** **on fighthealthcarefraud.com and select Report It**
- Calling the SIU fraud hotline, **866-847-8247**.
- Calling Anthem Customer Service at **800-450-8753**.

No individual who reports violations or suspected fraud, waste, or abuse will be retaliated against, and Anthem will make every effort to maintain anonymity and confidentiality.

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

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

When reporting concerns involving a PROVIDER (a doctor, dentist, counselor, medical supply company, etc.) include:

- Name, address, and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility if you have it
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

Examples of Member Fraud, Waste, and Abuse

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

When reporting concerns involving a MEMBER include:

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

Anthem monitors critical incidents and reports any occurrences and investigations of incidents to the state. This includes reports of wrongful death, restraints and medication errors resulting in injury. To report critical incidents, use any of the above listed methods for reporting suspected fraud, waste, and abuse.

Investigation Process

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

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

If you are working with the SIU, all checks and correspondence should be sent to:
Special Investigations Unit
740 W Peachtree Street NW
Atlanta, Georgia 30308
Attn: investigator name, #case number

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

About Prepayment Review
One method we use to detect FWA is through prepayment claim review. Through a variety of means, certain providers (facilities or professionals), or certain claims submitted by providers, may come to our attention for behavior that might be identified as unusual for coding, documentation, and/or billing issues, or claims activity that indicates the provider is an outlier compared to 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.
- The provider will be referred to other authorities as applicable and/or designated by the State.
- The SIU will refer all suspected criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

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

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

Anthem believes awareness and action are vital to keeping the state and federal programs safe and effective. Understanding the various opportunities for fraud, waste, or abuse and working with members to protect their Anthem identification cards can help prevent fraud, waste, and abuse.

Offsets. Anthem shall be entitled to offset claims and recoup an amount equal to any overpayments ("Overpayment Amount") or improper payments made by the health plan to Provider or Facility against any payments due and payable by Anthem to Provider or Facility with respect to any Health Benefit Plan under any contract with our company regardless of the cause. Provider or Facility shall voluntarily refund the Overpayment Amount regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by the Anthem that an Overpayment Amount is due from Provider or Facility, Provider or Facility must refund the Overpayment Amount within the timeframe specified in letter notifying the Provider or Facility of the Overpayment Amount. If the Overpayment Amount is not received within the timeframe specified in the notice letter, Anthem shall be entitled to offset the unpaid portion of the Overpayment Amount against other Claims payments due and payable by Anthem to Provider or Facility under any Health Benefit Plan in accordance with Regulatory Requirements. Should Provider or Facility disagree with any determination, Provider or Facility shall have the right to appeal such determination under Anthem procedures set forth in this Provider Manual, on condition that that such appeal shall not suspend Anthem right to recoup the Overpayment Amount during the appeal process unless required by Regulatory Requirements. Anthem reserves the right to employ a third-party collection agency in the event of non-payment.

Relevant Legislation
In order to meet the requirements under the *Deficit Reduction Act*, you must adopt the Anthem fraud, waste, and abuse policies and distribute them to any staff members or contractors who work with Anthem. If you have questions or would like more details concerning our fraud, waste, and abuse detection, prevention, and mitigation program, please contact the Anthem Chief Compliance Officer.

Electronic copies of our policy and the Anthem Code of Business Conduct and Ethics are available at **https://providers.anthem.com/ny**.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA, also known as the Kennedy-Kassebaum bill, was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of healthcare fraud, and simplifies the administration of health insurance.

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

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

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

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

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

The Anthem voice mail system is secure and password protected. When leaving messages for Anthem associates, providers should only leave the minimum amount of member information required to accomplish the intended purpose.

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

6 BEHAVIORAL HEALTH SERVICES

Behavioral Health Services

The Anthem Behavioral Health program was created to manage the needs of members seeking treatment for substance use and mental health problems. Anthem complies with state Medicaid guidance including managed care policy documents, relevant performance improvement specification documents or manuals, and policies governing prior authorization, concurrent or retrospective review. Specifically, we incorporate the following resources into our policies and procedures:

- Office of Mental Health's *Clinic Standards of Care* (**omh.ny.gov/omhweb/clinic_standards/care_anchors.html**)
- Office of Addiction Services and Support clinical guidance (**oasas.ny.gov/AdMed/recommend/recommendations.cfm**)
- Office of Health Insurance Programs' *Policy and Proposed Changes to Transition Children in Direct Placement Foster Care into Medicaid Managed Care,* April 2013 (**health.ny.gov/health_care/medicaid/redesign/docs/policy_and_proposed_changes_fc.pdf**)
- *OCFS Working Together: Health Services for Children/Youth in Foster Care Manual* (**http://ocfs.ny.gov/main/sppd/health_services/manual.asp**)
- Office of Health Insurance Programs' *Principles for Medically Fragile Children*, July 2014

Each member's treatment should be individualized and focused on improving the member's overall well-being. This should involve coordination of care with the member's PCP, other treating providers and referrals for community support services when necessary. To provide these comprehensive health services, Anthem will not exclude any appropriately registered, certified, or licensed type of provider as a class from participation with us.

Members do not need a referral from their PCP to access behavioral health services; however, the PCP should actively screen members for Mental Health and Substance Use and identify the need for behavioral health services for their patients and should remain involved in treatment planning for all patients with behavioral health needs. If a member is using a behavioral health clinic that also provides primary care services, the member may select the lead provider to be their PCP. Providers offering Substance Use services must use the Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) 3 assessment tool for level of care determination for all covered Substance Use Services. For mental health services, Anthem adopted medical necessity criteria will be used to assess medical necessity. For all substance use services, state approved LOCADTR 3 criteria will be used.

PCPs must actively collaborate and maintain documentation of these efforts with behavioral health practitioners when:

- The PCP is prescribing psychotropic medication.
- A medical condition exists that complicates a behavioral condition.
- There is a potential for adverse reaction between prescribed medications.
- The treating psychiatrist is prescribing a psychotropic medication that requires medical monitoring.

Collaboration is strongly encouraged to provide optimal care and to successfully identify and ensure the safety of the patient. Without collaboration, members may remain untreated if PCPs do not recognize members at risk for, or with, active mental or addictive disorders. Effective working relationships between providers and other treatment partners and service sites will result in improved continuity and coordination of care, increased member satisfaction and higher quality, efficiency, and effectiveness of services. All collaboration efforts should be documented in the medical record.

Behavioral healthcare practitioners should communicate with the member's PCP:

- For the exchange of clinical information, when necessary, that may aid in diagnosis and/or treatment.
- When the PCP's support for a treatment plan would enhance member satisfaction and/or compliance.
- When there are possible medical comorbidities and/or medication interactions that need to be considered.
- When the PCP has requested immediate feedback.

Anthem will conduct annual site visits at select providers' offices to provide education and training. These site visits will include a chart review to verify that collaboration of care and clinical documentation is occurring. In addition, Anthem will support provider access to 1) rapid consultations from child and adolescent psychiatrists and 2) referral and linkage support for child and adolescent patients.

Meeting the Needs of Children and Youth Members

Anthem ensures participating providers have expertise in caring for medically fragile children (including children with co-occurring developmental disabilities) so they receive services from appropriate providers. Participating providers should refer to appropriate, in-network community and facility providers to meet the needs of the child or seek authorization from Anthem for out-of-network providers when participating providers can't meet the child's needs. Anthem authorizes these services in accordance with established time frames in the *Medicaid Managed Care Model Contract* and OHIP's *Principles for Medically Fragile Children* (under EPSDT, HCBS, and CFCO rules) as well as with consideration for extended discharge planning.

Anthem works to comprehensively meet the needs of children and youth under 21 years of age with behavioral health (BH) and home- and community-based services (HCBS). This includes addressing the needs of medically fragile children, children with behavioral health diagnosis(es) and children in foster care (FC) with developmental disabilities.

Office of Persons with Developmental Disabilities

The Office of Persons with Developmental Disabilities (OPWDD) Home- and Community-Based Services (HCBS) waiver is a federally approved initiative permitting the state of New York to make certain services available under Medicaid, that're not typically included in the Medicaid state plan, for a targeted group of individuals with developmental disabilities and who meet specific eligibility criteria.

The waiver is intended to decrease the risk of institutionalization by providing personalized services in the community. These services are based on the needs, preferences, and personal goals of the consumer.

Waiver-funded services emphasize individualized services, community inclusion, independence, and productivity. The OPWDD HCBS waiver was designed to reduce costs while increasing choice and flexibility in service.

Who May Provide Care?
An incorporated, not-for-profit agency or governmental entity may apply to be a provider of waiver services. Individuals interested in becoming an authorized provider must obtain not-for-profit status. Evidence of article of incorporation noting the practitioner will provide services to persons with developmental disabilities will be required.

Interested agencies should contact the OPWDD Developmental Disabilities Services Office (DDSO) in their county.

Targeted Population
To be eligible to participate in the OPWDD HCBS waiver, an individual must:

- Be diagnosed with a developmental disability.
- Be eligible for intermediate care facility (ICF)/mental retardation (MR) level of care.
- Be eligible for Medicaid.
- Choose HCBS waiver services over institutional care.

An individual with a developmental disability and residing in New York can request enrollment in the HCBS waiver by contacting their county's DDSO.

Providers of waiver services must also be enrolled in the Medicaid program for billing and reimbursement purposes.

For additional information regarding the OPWDD HCBS waiver and other services available to persons with developmental disabilities, visit the OPWDD website at **opwdd.ny.gov**.

For a listing of DDSOs, visit **opwdd.ny.gov**.

Behavioral Health Authorization Requirements: Refer to the *Quick Reference Guide*.

Emergency Pharmacy Protocols — CHPlus members only
Except where otherwise prohibited by law, for members with a behavioral health condition we will:

- Allow immediate access, without prior authorization, to a 72-hour emergency supply of a prescribed drug or medication when the member experiences an emergency condition, as defined within this manual.
- Immediately authorize a seven-day supply of a prescribed drug or medication associated with the management of opioid withdrawal and/or stabilization.
- For additional information regarding Pharmacy covered services, please see Chapter 5 – Pharmacy Services section of this manual.

Member Services
Our member services are available between 8 a.m. and 8 p.m. After 8 p.m. providers can call and get authorizations for inpatient behavioral health services. Members can also call, and our clinicians are available to assess and direct members to the needed supports.

Behavioral Health Access and Availability

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

Anthem is dedicated to arranging access to care for our members. Anthem's ability to provide quality access depends upon the accessibility of network providers. Providers are required to adhere to the following access standards for members 21 years of age and older:

Appointment type	Appointment standard
Emergent or emergency visits	Immediately upon presentation
Urgent visits	Within 24 hours of request or sooner as clinically indicated
Care for non-life-threatening emergency	Within 6 hours
Initial visit for routine care	Within 10 business days
Nonurgent symptomatic visits	Within 48 to 72 hours of request or sooner as clinically indicated
Routine nonurgent, preventive appointments	Within four weeks of request or sooner, as clinically indicated
Follow-up routine care appointments: Specialist referrals (not urgent) Adult baseline, routine physicals	 Within four to six weeks of request Within 12 weeks from enrollment
Pursuant to an emergency or hospital discharge, mental health or substance or release from incarceration, if known, follow-up visits with a participating provider (as included in the benefit package)	Within five days of request or as clinically indicated
Nonurgent mental health or substance use visits with a participating provider (as included in the benefit package)	Within two weeks of request
Provider visits to make health, mental health and substance use assessments for the purpose of making recommendations regarding a recipient's ability to perform work when requested by an LDSS	Within 10 days of request by an Anthem member
For CPEP, inpatient mental health, inpatient detoxification SUD services and crisis intervention services	Immediately upon presentation at a service delivery site
Urgently needed SUD inpatient rehabilitation services, stabilization treatment services in OASAS-certified residential setting and mental health or SUD outpatient clinics, assertive community treatment (ACT) personalized recovery-oriented services (PROS) and opioid treatment programs	Within 24 hours of request
Behavioral health specialist referrals (nonurgent): CDT, and rehabilitation services for residential SUD treatment services PROS programs other than clinic services	 Within two to four weeks of request Within two weeks of request
Nonurgent mental health or SUD with a participating provider that is a mental health and/or SUD outpatient clinic, including a PROS with clinical treatment	Within one week of request
Short-term and intensive crisis respite	Within 24 hours of request
Psychosocial rehabilitation, community psychiatric support and treatment, habilitation services, family support and training	Within two weeks of request (unless appointment is pursuant to an emergency or hospital discharge or release from incarceration, in which case the standard is five days of request)
Education and employment support services	Within two weeks of request
Peer support services	Within one week of request (Unless appointment is pursuant to emergency or hospital discharge, in

Appointment type	Appointment standard
	which case the standard is five days. Or, if peer support services are needed urgently for symptom management, the standard is 24 hours.)

Providers are required to adhere to the following access standards for members under 21 years of age:

Service type	Emergency	Urgent	Nonurgent MH/SUD	BH specialist	Follow-up to emergency or hospital discharge	Follow-up to residential services, detention discharge or discharge from justice system placement
Mental health outpatient clinic/PROS clinic		Within 24 hours	Within 1 week		Within 5 business days of request	Within 5 business days of request
ACT		Within 24 hours for AOT		N/A	Within 5 days of request	
PROS		Within 24 hrs. of request	Within 2 weeks		Within 5 days of request	Within 5 days of request
Continuing day treatment				2 to 4 weeks		Within 5 days of request
Partial hospitalization					Within 5 business days of request	
Inpatient psychiatric services	Upon presentation					
CPEP	Upon presentation					
OASAS outpatient clinic		Within 24 hours	Within 1 week of request		Within 5 business days of request	Within 5 business days of request
Detoxification	Upon presentation					
SUD inpatient rehabilitation	Upon presentation	Within 24 hours				
OASAS opioid treatment program		Within 24 hours	Within 1 week of request		Within 5 business days of request	Within 5 business days of request
OASAS Part 820 Residential Services		Within 24 hrs. of request		2-4 weeks	Within 5 days of request	
Rehabilitation services for residential SUD treatment supports				2 to 4 weeks	Within 5 days of request	
1915(i)-like Home- and Community-Based Services						
Rehabilitation and habilitation	N/A	N/A	Within 2 weeks of request		Within 5 days	

Service type	Emergency	Urgent	Nonurgent MH/SUD	BH specialist	Follow-up to emergency or hospital discharge	Follow-up to residential services, detention discharge or discharge from justice system placement
Crisis Intervention (Mobile Crisis, Crisis Residence, Crisis Stabilization)	Upon presentation	Within 24 hours for crisis residence	N/A		Immediate	
Crisis respite	Within 24 hours	Within 24 hours	N/A		Within 24 hours of request	
Educational and employment support services	N/A	N/A	Within 2 weeks of request		N/A	
Prevocational services	N/A	N/A	Within 2 weeks of request		N/A	Within 2 weeks of request
Peer support/family peer support	N/A	Within 24 hours of request	Within 1 week of request		Within 72 hours of request	Within 72 hours of request
Core Services [3]						
Psychosocial Rehabilitation (PSR), Community Psychiatric Support and Treatment (CPST), Family Support and Training (FST)			Within 2 weeks of request		Within 5 days of request or as clinically indicated	Within 5 days of request or as clinically indicated
Peer Supports		Within 24 hrs. of request	Within 1 week of request		Within 5 days of request	
Children's Standard						
CPST		Within 24 hours (for intensive in-home and crisis response)	Within 1 week of request		Within 72 hours of discharge	Within 72 hours

[3] Additional information about the CORE services can be found online at: **https://omh.ny.gov/omhweb/bho/core/**

Service type	Emergency	Urgent	Nonurgent MH/SUD	BH specialist	Follow-up to emergency or hospital discharge	Follow-up to residential services, detention discharge or discharge from justice system placement
OLP		Within 24 hours of request	Within 1 week of request		Within 72 hours of request	Within 72 hours of request
Youth peer support and training			Within 1 week of request		Within 72 hours of request	Within 72 hours of request
PSR		Within 72 hours of request	Within 5 business days of request		Within 72 hours of request	Within 72 hours of request
Caregiver/family supports and services			Within 5 business days of request		Within 5 business days of request	Within 5 business days of request
Planned respite			Within 1 week of request		Within 1 week of request	
Supported employment			Within 2 weeks of request			Within 2 weeks of request
Community self-advocacy training and support			Within 5 business days of request			Within 5 business days of request
Habilitation			Within 2 weeks of request			
Palliative care			Within 2 weeks of request		Within 24 hours of request	

Behavioral Health Case Management

Anthem offers case management services. Providers can refer members who may benefit from case management to Anthem. Typically, members who are in case management are those members who have complex needs or are in need of community supports to support their plan of care. If a member is in need of case management and is enrolled in a Health Home, the plan will link the member to the Health Home or will work with the provider to ensure this happens. Members who are experiencing homelessness, are restricted, have had their first break (FEP), are transitioning from foster care or aging out of the children's system (TAY) are some of the members who are offered case management services. Providers are expected to link these members who have complex needs to supports. If the provider is unable to link a member to these supports directly, the provider is expected to reach out to the health plan to ensure member needs are met.

The plan expects the providers to work with Health Homes if a member is enrolled with a Health Home. If there are challenges the plan will coordinate with the provider and the Health Home as needed. Some

examples when this type of coordination should occur are when a member is discharged from an IP stay, and when there are gaps in a member's care.

The plan expects behavioral health providers to be able to see members even if there is no scheduled appointment to assess whether the member needs urgent care and/or triage. For Health and Recovery Plan (HARP) members, the Health Home completes the Community Mental Health Assessment (Inter Rai) and offers the member choices of in-network HCBS providers if the assessment indicates a need for HCBS services. The HCBS provider will work with the plan and Health Home to ensure that the member's plan of care for HCBS is person-centered. Health Homes are expected to incorporate the HCBS plan of care within the member's overall plan of care. HCBS providers are expected to contact the plan for authorization of HCBS services. The plan uses state-approved medical necessity criteria to authorize HCBS services.

The plan of care is expected to be person-centered, strength-based and recovery-focused, and is expected to take member's wishes and choices into consideration. The health plan will work with Health Homes to collaborate and support them to improve member outcomes.

HARP members follow the same complaints and grievance process as all Medicaid members within the health plan.

Members in Foster Care

Initial Health Assessments

A series of assessments provides a complete picture of the foster care child's health needs and is the basis for developing a comprehensive plan of care. Initial health activities include all of the following:

- An immediate screening of the child's medical condition, including assessment for child abuse/neglect
- A comprehensive health evaluation that includes all EPSDT elements as required by the state Medicaid program; specifically for children in foster care, EPSDT screenings must be completed within 30 days of entering care in conjunction with the comprehensive health evaluation. The EPSDT screen must include federally mandated aspects related to the following:
    - A comprehensive health and developmental history including a physical exam, immunizations, laboratory tests (including lead toxicity screening) and health education
    - Hearing
    - Dental (including ongoing preventive and restorative care)
    - Mental health/substance use disorder
    - Vision
    - Follow-up health evaluation and treatments that incorporate information from the five initial assessments
    - Ongoing efforts to obtain the child's existing medical records and document medical activities

Anthem will ensure there's sufficient network capacity to complete the required foster care initial health assessments within the time frames listed in the following table:

Time frame	Activity	Mandated activity	Mandated time frame	Who performs
24 hours	Initial screening/ screening for abuse/ neglect	X	X	Health practitioner (preferred) or child welfare caseworker/health staff

Time frame	Activity	Mandated activity	Mandated time frame	Who performs
5 days	Initial determination of capacity to consent for HIV risk assessment & testing	X	X	Child welfare caseworker or designated staff
5 days	Initial HIV risk assessment for child without capacity to consent	X	X	Child welfare caseworker or designated staff
10 days	Request consent for release of medical records & treatment	X	X	Child welfare caseworker or health staff
30 days	Initial medical assessment	X	X	Health practitioner
30 days	Initial dental assessment	X	X	Health practitioner
30 days	Initial mental health assessment	X		Mental health practitioner
30 days	Family Planning Education and Counseling and follow-up healthcare for youth age 12 and older (or younger as appropriate)	X	X	Health practitioner
30 days	HIV risk assessment for child with possible capacity to consent	X	X	Child welfare caseworker or designated staff
30 days	Arrange HIV testing for child with no possibility of capacity to consent & assessed to be at risk of HIV infection	X	X	Child welfare caseworker or health staff
45 days	Initial developmental assessment	X		Health practitioner
45 days	Initial substance use assessment			Health practitioner
60 days	Follow-up health evaluation			Health practitioner
60 days	Arrange HIV testing for child determined in follow-up assessment to be	X	X	Child welfare caseworker or health staff

Time frame	Activity	Mandated activity	Mandated time frame	Who performs
	without capacity to consent & assessed to be at risk of HIV infection			
60 days	Arrange HIV testing for child with capacity to consent who has agreed in writing to consent to testing	X	X	Child welfare caseworker or health staff

Relocations

If an Anthem member in foster care is placed in another county and Anthem operates in the new county, the child can transition to a new PCP and other healthcare providers without disrupting the care plan in place. If the member is placed outside Anthem's service area, Anthem will ensure access to providers with expertise in treating children involved in foster care. This ensures continuity of care and the provision of all medically necessary services.

Children placed in Foster Care (Voluntary Foster Care Agencies)
Children/youth placed in foster care, including those in direct placement foster care and placement in the care of VFCAs statewide, will be mandatorily enrolled in Medicaid managed care (MMC) unless the child/youth is otherwise exempt or excluded from enrollment. Exemptions and exclusions from MMC enrollment are included in the 1115 Medicaid Redesign Team Waiver Special Terms and Conditions at **health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm**

We are responsible for providing most Benefit Package services to enrolled children/youth placed in foster care, promoting continuity of care, and ensuring healthcare services are delivered in a trauma-informed manner and consistent with standards of care recommended for children in foster care. Children/youth often enter foster care without having had access to traditional preventive healthcare services. As a result, children/youth in foster care require an increase in the frequency of their health monitoring. Pharmacy benefit for Foster Care members is administered by Medicaid NYRx.
health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/vol_foster_trans.htm

Behavioral Health Credentialing

Anthem credentials OMH- and OASAS-licensed providers as well as other NYS-designated providers, such as voluntary foster care agencies, state-designated entities, home- and community-based waiver service providers. We will accept all state-designated licenses and certifications in place of any credentialing process for individual employees, subcontractors, or agents of such providers. The provider shall collect, and will accept, program integrity related information as part of the licensing and certification process.

We require all licensed providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

Anthem requires that such providers do not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

For designated HCBS providers:

- The plan will accept state-issued HCBS designation in place of a plan credentialing process for HCBS providers and any individual employees, subcontractors, or agents.
- The plan will collect and accept program integrity related information as part of the licensing and certification process.

For additional information regarding the credentialing process, please see Chapter 12 of this manual.

Quality Management

We maintain a comprehensive Behavioral Health Quality Management program to objectively monitor and systematically evaluate the care and service provided to members. The scope and content of the program reflects the demographic and epidemiological needs of the population served. Members and providers have opportunities to make recommendations for areas of improvement.

The plan's Utilization and Quality Management program description and work plan speaks to the Utilization Management and Quality Management activities that the plan focuses on for the year. The work plan activities, including those by the Behavioral Health Quality Management Committee, are monitored and reported to the Medical Advisory and Quality Management Committees. Providers, peer specialists, members, family members, youth and family peer support specialists, and child-serving providers are part of the committees and guide and provide feedback on our activities.

The Behavioral Health Quality Management Committee is accountable to and reports regularly to the governing board or its designee. Our behavioral health quality management director leads the committee and maintains records. Focused discussions, tracking, trending, analysis and follow-up will be documented as a separate item in Behavioral Health Quality Management Committee agendas and minutes if they're related to the following:

- Physical health services for medically fragile children
- Physical health services for children with complex conditions
- Behavioral health services and HCBS for children

Quality Services

Anthem encourages all of our providers to review the clinical practice guidelines the plan develops and posts on our website. Anthem follows behavioral health guidelines recommended by the American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP). When developing or updating our behavioral health clinical practice guidelines, Anthem uses the following sources:

- Substance and Mental Health Services Administration (SAMHSA)
- National Institute of Mental Health (NIMH)
- American Society of Addiction Medicine
- National Institute on Drug Abuse
- National Alliance of Mental Illness
- United States Department of Health and Human Services

Anthem applies current, relevant, and researched recommendations across the states we serve.
We disseminate and monitor fidelity to clinical practice guidelines through our ongoing care management process and peer-to-peer engagement with providers. Through this process, care managers:

- Assess whether a member's care meets clinical practice guidelines and then address concerns with providers
- Engage providers to access CPGs on the provider website and in newsletters
- Discuss specific guidelines with providers and Health Homes
- Host periodic, topic-specific provider webinars to address identified trends
- Maintain on-going contact with members, their families, caregivers, treating providers, and Health Homes to monitor progress and refine the plan of care
- Deliver and monitor interventions to meet care plan goals and share member progress toward achieving those goals

Anthem enlists all providers to participate in our care planning process. During this process, our care manager engages the member's PCP and any other treating providers by calling them to gather information on the member's history and healthcare needs and solicit input into the care plan. Our care managers maintain communication and collaboration with the member's PCP, other active specialty providers, and other members of the healthcare team to assess progress in meeting care plan goals.

Providers are encouraged to use existing training resources such as web-based evidence-based practice training available through New York's Center for Practice Innovations (CPI) at Columbia University.

Trainings can be completed by Anthem on these guidelines when requested by the provider. PCPs should screen for behavioral health conditions (screening tools are posted on our website) and members should be linked to in-network behavioral health providers.

Other trainings on the following topics will be offered by Anthem:

- Recovery principles
- Person-centered planning, including plan of care development and review
- HCBS overview, eligibility assessment and services
- Treatment of medically fragile children
- Billing, coding, data interface, documentation requirements, provider profiling programs and utilization management requirements for children's services
- Cultural competency

Providers are expected to attend either an offered training or another acceptable training on these topics.

Anthem expects providers to support the state and Anthem on transforming the behavioral health system. Providers are expected to adopt and offer services that are person-centered and recovery-focused. Providers are expected to follow the evidenced-based practice for First Episode Psychosis for members who experience their first break.

Providers are required to develop policies and procedures that cover the following topics and assure confidentiality of mental health and substance use related information. The policies and procedures must include:

- Initial and annual in-service education of staff, contractors
- Identification of staff allowed access and limits of access
- Procedure to limit access to trained staff (including contractors)
- Protocol for secure storage (including electronic storage)
- Procedures for handling requests for behavioral health and substance use information protocols to protect persons with behavioral health and/or substance use disorder from discrimination
- Members who present for unscheduled nonurgent care, with the aim of promoting enrollee access to appropriate care

Anthem is required to submit to OMH and OASAS a quarterly report of any deficiencies in performance and corrective action taken with respect to OMH and OASAS licensed, certified, or designated providers. Anthem will report any serious or significant health and safety concerns to OMH and OASAS immediately upon discovery.

Paper Claims Submission

Providers also have the option of submitting paper claims. Anthem uses Optical Character Reading (OCR) technology as part of our front-end claims processing procedures. To use OCR technology, claims must be submitted on original red claim forms (not black and white or photocopied forms), and laser printed or typed (not handwritten) in a large, dark font. You must submit a properly completed *UB-04* or *CMS-1500* (current form) within 90 days from the date of service.

Anthem cannot accept claims with alterations to billing information. Claims that have been altered will be returned with an explanation of the reason for the return. We will not accept entirely handwritten claims. Paper claims must be submitted within 90 days of the date of service and submitted to the following address:

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

Facility claims must be submitted with the following:

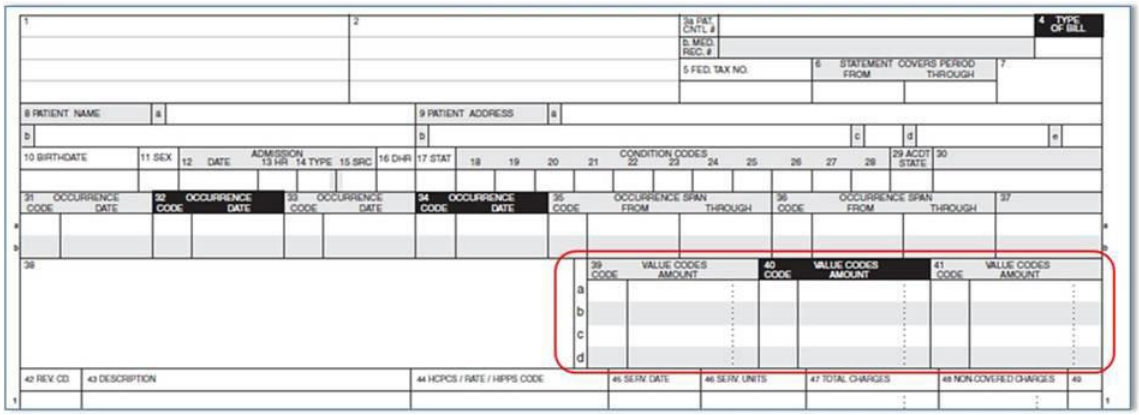
- Form type for Medicare and Medicaid: *UB-04* submission
- Valid value code, if applicable
- Valid rate code, if applicable
- Valid revenue code
- Valid CPT code
- Valid diagnosis code that falls within the mental health category
- Bill type must be 731 for initial claims or 737 for corrected claims

Individual/group practice claims must be submitted with the following:

- Form type for Medicare and Medicaid: *CMS-1500* submission
- Valid CPT code

Placement of value and rate codes:

- Value code is 24 (39a.)
- Rate code should be placed before the dotted line



Rejected and Denied Claims

Providers will receive a notice if a claim is rejected or denied. A rejected claim is a claim that does not enter the adjudication system due to missing or incorrect information. A denied claim is a claim that goes through the adjudication process but is denied for payment.

Routine Claim Inquiries

Anthem's Provider Experience Program ensures provider claim inquiries are handled efficiently and in a timely manner. Calls are handled by a specially trained call agent in Provider Services. Providers may call **800-454-3730** for claims inquiries.

Behavioral Health Denials, Grievances, and Appeals
All denial, grievance, and appeal decisions are conducted by a peer and are subject to specific behavioral health requirements including:

- A physician board-certified in general psychiatry at the plan reviews all inpatient level of care denials for psychiatric treatment
    - A physician board-certified in child psychiatry reviews all inpatient denials for psychiatric treatment and denials for behavioral health medications for members under 21 years of age.
- A physician certified in addiction treatment reviews all inpatient level of care/continuing stay denials for SUD treatment
- A physician reviews all denials for services for a medically fragile child, taking the needs of the family/caregiver into consideration.

Anthem will not deny coverage of an ongoing course of care unless an appropriate provider of alternate level care is approved.

For additional information on the denial, grievance, and appeals processes, please see Chapter 9 of this manual.

7 MEMBER MANAGEMENT SUPPORT

Welcome Call

As part of our member management strategy, we offer a welcome call to new members. During the welcome call, new members who have been identified through their health risk assessment as possibly needing additional services are educated regarding the health plan and available services. Additionally, Member Services representatives offer to assist the member with any current needs, such as scheduling an initial checkup, assisting new members whose healthcare provider is not a member of the network and requesting to continue an ongoing course of treatment with the member's current provider. Circumstances would include if the member has:

- A life-threatening disease or condition or a degenerative and disabling disease or condition (the transitional period is up to 60 days).
- Entered the second trimester of pregnancy at the effective date of enrollment (the transitional period includes provision of postpartum care related to the delivery).

Appointment Scheduling

Anthem, through our participating providers, ensures members have access to primary care services for routine, urgent and emergency services and to specialty care services for chronic and complex care. Providers will respond to an Anthem member's needs and requests in a timely manner. The PCP should make every effort to schedule Anthem members for appointments using the guidelines outlined in the PCP Access and Availability section of this manual.

24/7 NurseLine

The Anthem 24/7 NurseLine is a service designed to support the provider by offering information and education about medical conditions, healthcare, and prevention to members after normal physician practice hours. The 24/7 NurseLine provides triage services and helps direct members to appropriate levels of care. The Anthem 24/7 NurseLine telephone number is **800-300-8181** and is listed on the member's ID card. This ensures members have an additional avenue of access to healthcare information when needed. Features of the 24/7 NurseLine include:

- Constant availability — 24 hours a day, 7 days a week
- Access to information based upon nationally recognized and accepted guidelines
- Free translation services for 200 different languages and for members with difficulty hearing
- Education for members about appropriate alternatives for handling nonemergent medical conditions
- Provider updates — A nurse faxes the member's assessment report to the provider's office within 24 hours of the call

Emergency Behavioral Health Calls

When a member in crisis contacts Anthem using the toll-free number, the member may bypass the prompts and be connected directly to a call center agent. The member in crisis is then connected to the first available behavioral health agent. If the member does not choose this option, then the member has the option to select the type of assistance needed — either physical or behavioral health. If the member chooses the physical health option and the Member Services agent determines that the member may be in crisis, the call is then transferred to a Behavioral Health agent.

The Behavioral Health agent will determine if the call is a true crisis situation. In the event it is a crisis, the call is transferred to a licensed clinician to handle the call. The member is kept on the phone until a clinician comes on the line. The clinician engages the member and based on the discussion, the clinician may determine that the member needs to be screened at the emergency room. If the clinician makes the determination that the member needs to be screened, the clinician will obtain the assistance of a backup clinician or agent to assist with the call to 911 while the clinician keeps the member on the phone until emergency services arrive to assist the member.

The clinician that services the call will document the call and contact the health plan case manager if the member is in Case Management or to the Manager of Case Management for further assistance and follow up. This allows the member to receive additional follow-up and services as needed to prevent future crisis situations.

Crisis calls are handled the same way during normal business hours, after-hours, and weekends. All crisis calls are answered by a live person.

Interpreter Services
Interpreter services are available for our members if needed. Contact your Provider Relations representative for details.

Health Promotion

Anthem strives to improve healthy behaviors, reduce illness, and improve the quality of life for our members through comprehensive programs. Educational materials are developed or purchased and disseminated to our members, and health education classes are coordinated with community organizations and network providers who are contracted with Anthem.

Anthem manages projects that offer our members education and information regarding their health. Ongoing projects include:

- Member newsletter
- Creation and distribution of Health Tips, the Anthem health education tool used to inform members of health promotion issues and topics
- Health Tips on Hold (educational telephone messages while the member is on hold)
- Development of health education curricula and procurement of other health education tools (for example, breast self-exam cards)
- Relationship development with community-based organizations to enhance opportunities for members

Health Home

A Health Home is a care management service model whereby all of a patient’s caregivers communicate with one another so that all needs are addressed in a comprehensive manner. This is done primarily through a dedicated "care manager" who oversees and provides access to all of the services the patient needs to ensure they receive everything necessary to stay healthy, out of the emergency room and out of the hospital. Health records are shared (either electronically or paper) among providers so that services are not duplicated or neglected. The health home services are provided through a network of organizations – providers, health plans and community-based organizations. When all the services are considered collectively they become a virtual **Health Home**.

New York state (NYS), following CMS approval, initiated a Health Home program for Medicaid members with chronic medical and behavioral conditions effective **January 2012**. Health Home eligibility criteria requires members to have one or more of the following:

- Two or more chronic conditions (for example, mental health condition, substance use disorder, asthma, diabetes, heart disease, BMI over 25 or other chronic conditions)
- One qualifying chronic condition (for example, HIV/AIDS) and the risk of developing another
- One serious mental illness

Case Management

Case management is designed to proactively respond to a member's needs when conditions or diagnoses require care and treatment for long periods of time. When a member is identified (usually through precertification, admission review and/or provider or member request), the case manager (an Anthem nurse or social worker) helps to identify medically appropriate alternative methods or settings in which care may be delivered.

A provider, on behalf of the member, may request participation in the program. The case manager will work with the member, provider and/or hospital to identify the necessary:

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

The Anthem case manager will assist the member, Utilization Review team, and PCP and/or hospital in developing the discharge plan of care, ensuring the member's medical needs are met, and linking the member with community resources and Anthem programs for outpatient case and/or disease management. Anthem case managers are available from 9 a.m. to 5 p.m. ET. For more information regarding case management services or to refer a member, contact Provider Services at **800-450-8753**.

A member or a member designee can request case management services by calling Member Services at **800-300-8181**.

Condition Care

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

- Asthma
- Bipolar Disorder
- Chronic Obstructive Pulmonary Disease
- Coronary Artery Disease
- Congestive Heart Failure
- Diabetes

- HIV/AIDS
- Hypertension
- Major Depressive Disorder – Adult
- Major Depressive Disorder – Child and Adolescent
- Schizophrenia
- Substance Use Disorder

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

Program features include:

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

The Anthem condition care programs are based on nationally approved evidence-based clinical practice guidelines located at **https://providers.anthem.com/ny**. You can print a copy of the guidelines right from the site, or you can request a hard copy by calling Provider Services at **800-450-8753**.

Who is Eligible?
All Anthem members with one or more of the conditions listed conditions are eligible for condition care services.

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

Condition Care Provider Rights and Responsibilities
The provider has the right to:

- Have information about Anthem services, its staff's qualifications, and any contractual relationships.
- Decline to participate in or work with Anthem programs and services for their patients if the client's contract allows.
- Be informed of how Anthem coordinates interventions and treatment plans for individual patients.
- Know how to contact the person responsible for managing and communicating with the provider's patients.

- Be supported by the organization when interacting with patients to make decisions about their healthcare.
- Receive courteous and respectful treatment from Anthem staff.
- Communicate complaints to Anthem.

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

Contact Information
You can call a CNDC team member at **888-830-4300**. Members and providers can find out more about our CNDC programs by visiting **https://providers.anthem.com/ny**.

Health Education Advisory Committee

The Health Education Advisory Committee provides advice to Anthem regarding health education and outreach-related program development. The committee strives to ensure that materials and programs meet cultural competency requirements and are both understandable to the member and address the member's health education needs.

The Health Education Advisory Committee's responsibilities are to:
- Identify health education needs of the membership based on review of demographic and epidemiologic data.
- Identify cultural values and beliefs that must be considered in developing a culturally competent health education program.
- Assist in the review, development, implementation and evaluation of the member health education tools for the outreach program.
- Review the health education plan and make recommendations on health education strategies.

Women, Infants and Children Program

The mission of the Division of Women, Infants and Children (WIC) Services in the Bureau of Maternal and Child Health is to provide leadership that assures the health and well-being of women, infants, and children.

The WIC program impacts the health of mothers and children in the medically needy population. Optimal nutritional status during pregnancy and early childhood provides the best chance for the future of New York residents. For more information, please visit **health.state.ny.us/prevention/nutrition/wic**.

Network providers are expected to coordinate with the WIC program. Coordination includes referring potentially eligible women, infants and children and reporting appropriate medical information to the WIC program.

8 PROVIDER RESPONSIBILITIES

Medical Home

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

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

Responsibilities of the PCP

The PCP is a network physician who has the responsibility for the complete care of their members, whether providing it themselves or by referral to the appropriate provider of care within the network. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) may be included as PCPs. Below are highlights of the PCP's responsibilities.

The PCP shall:

- Manage the medical and healthcare needs of members, including monitoring and following up on care provided by other providers (including FFS).
- Coordinate referrals to specialists and FFS providers (both in- and out-of-network); and maintain a medical record of all services rendered by the PCP and other providers.
- Provide 24-hour-a-day, 7-day-a-week coverage; regular hours of operation should be clearly defined and communicated to members.
- Provide services ethically and legally, provide all services in a culturally competent manner and meet the unique needs of members with special healthcare needs.
- Participate in any system established by Anthem to facilitate the sharing of records, subject to applicable confidentiality and *HIPAA* requirements.
- Make provisions to communicate in the language or fashion primarily used by their membership.
- Participate and cooperate with Anthem in any reasonable internal and external quality assurance, utilization review, continuing education and other similar programs established by Anthem.
- Participate in and cooperate with the Anthem complaint and grievance procedures (Anthem will notify the PCP of any member grievance).

- Not balance-bill members; however, the PCP is entitled to collect applicable copayments, coinsurance or permitted deductibles for certain services.
- Continue care in progress during and after termination of their contract for up to 90 days until a continuity-of-care plan is in place to transition the member to another provider or through 60 days postpartum care for pregnant members in accordance with applicable state laws and regulations.
- Comply with all applicable federal and state laws regarding the confidentiality of patient records.
- Develop and have an exposure control plan in compliance with Occupational Safety and Health Administration standards regarding blood-borne pathogens.
- Establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act.
- Support, cooperate, and comply with the Anthem Quality Improvement Program initiatives and any related policies and procedures and provide quality care in a cost-effective and reasonable manner.
- Inform Anthem if a member objects to provisions of any counseling, treatments, or referral services for religious reasons.
- Treat all members with respect and dignity.
- Provide members with appropriate privacy and treat member disclosures and records confidentially, giving the members the opportunity to approve or refuse their release.
- Provide members with complete information concerning their diagnosis, evaluation, treatment, and prognosis and give members the opportunity to participate in decisions involving their healthcare, except when contraindicated for medical reasons, the information will be made available to an appropriate person acting on the member's behalf.
- Advise members about their health status, medical care or treatment options, regardless of whether benefits for such care are provided under the program and advise members on treatments which may be self-administered.
- When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings.
- Have a policy and procedure to ensure proper identification, handling, transport, treatment, and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.
- Agree to maintain communication with the appropriate agencies such as local police, social services agencies, and poison control centers to provide high-quality patient care.
- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of the clinical research shall be clearly contrasted with entries regarding the provision of non-research-related care.

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

Provider and Facility Digital Guidelines

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

Anthem expects Providers and Facilities will utilize digital tools, unless otherwise prohibited by law or other legal requirements.

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

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

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

Digital guidelines available through Availity Essentials include:

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

Additional digital applications available to Providers and Facilities include:

- Pharmacy prior authorization drug requests
- Services through Carelon Medical Benefits Management, Inc.
- Services through Carelon Behavioral Health, Inc.

Anthem expects Providers and Facilities transacting any functions and processes above will use available digital and/or electronic self-service applications in lieu of manual channels (paper, mail, fax, call, chat, etc.). All channels are consistent with industry standards. All EDI transactions use version 5010.
Note: As a mandatory requirement, all trading partners must currently transmit directly to the Availity EDI gateway and have an active Availity Trading Partner Agreement in place. This includes providers using their practice management software & clearinghouse billing vendors.

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

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

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

- EDI transaction: X12 270/271 – eligibility inquiry and response
    - Anthem supports the industry standard X12 270/271 transaction set for eligibility and benefit inquiry and response as mandated by HIPAA.
- Availity Essentials
    - The Eligibility and Benefits Inquiry verification application allows a Provider and Facility to key an inquiry directly into an online eligibility and benefit look-up form with real-time responses.
- Provider desktop integration via B2B APIs
    - Anthem has also enabled real-time access to eligibility and benefit verification APIs that can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration opportunities.

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

- EDI transaction: X12 278 – prior authorization and referral:
    - Anthem supports the industry standard X12 278 transaction for prior authorization submission and status inquiry as mandated per HIPAA.
- EDI transaction: X12 275 – patient information, including HL7 payload for authorization attachments:
    - Anthem supports the industry standard X12 275 transaction for electronic transmission of supporting authorization documentation including medical records via the HL7 payload.
- Availity Essentials:
    - Authorization applications include the Availity Essentials multi-payer Authorization and Referral application and the Interactive Care Reviewer (ICR) for authorization submissions not accepted through Availity Essentials' multi-payer application.

        - Both applications enable prior authorization submission, authorization status inquiry and the ability to review previously submitted authorizations.
        - Authorization/Referral Inquiry can be used to find/locate authorization cases submitted outside of Availity Essentials (e.g., phone/fax) and located cases can be pinned to Authorization/Referral Dashboard for easy access on case status later

- Provider desktop integration via B2B APIs:
    - Anthem has enabled real-time access to prior authorization APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

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

- EDI transaction: X12 837 – Professional, institutional, and dental Claim submission (version 5010):
    - Anthem supports the industry standard X12 837 transactions for all fee-for-service and encounter billing as mandated per HIPAA.
    - 837 Claim batch upload through EDI allows a provider to upload a batch/file of Claims (must be in X12 837 standard format).
- EDI transaction: X12 276/277 – Claim status inquiry and response:
    - Anthem supports the industry standard X12 276/277 transaction set for Claim status inquiry and response as mandated by HIPAA.
- Availity Essentials: The Claims & Payments application enables a provider to enter a Claim directly into an online Claim form and upload supporting documentation for a defined Claim.
    - Claim Status application enables a provider to access online Claim status. Access the Claim payment dispute tool from Claim Status. Claims Status also enables online claim payment disputes in most markets and for most claims. It is the expectation of Anthem that electronic Claim payment disputes are adopted when and where it is integrated.
- Provider desktop integration via B2B APIs:
    - Anthem has also enabled real-time access to Claim Status via APIs, which can be directly integrated within participating vendor's practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

Claim attachments
Providers and Facilities should leverage these channels for electronic Claim attachments from **https://Availity.com**:

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

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

- Availity Essentials – Claim Status application enables a Provider or Facility to digitally submit supporting Claims documentation, including medical records, directly to the Claim.
  - Digital Request for Additional Information (Digital RFAI) – The Medical Attachments application on Availity Essentials enables the transmission of digital notifications when additional documentation including medical records are needed to process a Claim.

Section 5: Electronic remittance advice and electronic claims payment

Electronic remittance advice

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

To stop receiving ERAs for your claims, contact Availity Client Services at **1-800-AVAILITY** (**282-4548**).
To re-enable receiving paper remittances, contact Provider Services.

Electronic claims payment

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

- **Electronic Funds Transfer (EFT)**

  Electronic funds transfer (EFT) uses the automated clearinghouse (ACH) network to transmit healthcare payments from a health plan to a Provider's or Facility's bank account at no charge for the deposit. Health plans can use a Provider's or Facility's banking information only to deposit funds, not to withdraw funds. The EFT deposit is assigned a trace number (TRN) to help match the payment to the correct 835 electronic remittance advice (ERA), a process called reassociation.

  To enroll in EFT: Providers and Facilities can register, enroll, and manage account changes for EFT through EnrollSafe at **enrollsafe.payeehub.org**. EnrollSafe enrollment eliminates the need for paper registration. EFT payments are deposited faster and are generally the lowest cost payment method. For help with enrollment, **use this convenient EnrollSafe User Reference Manual**.

  To disenroll from EFT: Providers and Facilities are entitled to disenroll from EFT. Disenroll from EFT payments through EnrollSafe at **enrollsafe.payeehub.org**.

- **Virtual Credit Card (VCC)**

For Providers and Facilities who don't enroll in EFT, and in lieu of paper checks, Anthem is shifting some reimbursements to virtual credit card (VCC). VCC allow Providers and Facilities to process payments as credit card transactions. Check with your merchant processor regarding standard transaction fees that will apply.
Note that Anthem may receive revenue for issuing a VCC.
Opting out of virtual credit card payment. Providers and Facilities are entitled to opt out of electronic payment. To opt out of virtual credit card payment, there are two (2) options:

- Enrolling for EFT payments automatically opts you out of virtual credit card payments. To receive EFT payments instead of virtual credit cards payments, enroll for EFT through EnrollSafe at **enrollsafe.payeehub.org**.

  OR

- To opt out of virtual credit card payments, contact Comdata at **800-833-7130** and provide your taxpayer identification number.

- **Zelis Payment Network (ZPN) electronic payment and remittance combination**

  The Zelis Payment Network (ZPN) is an option for Providers and Facilities looking for the additional services Zelis can offer. Electronic payment (ACH or VCC) and Electronic Remittance Advice (ERA) via the Zelis portal are included together with additional services. For more information, go to **Zelis.com**. Zelis may charge fees for their services.
  Note that Anthem may receive revenue for issuing ZPN.
  ERA through Availity is not available for Providers and Facilities using ZPN.
  To disenroll from ZPN payment, there are two (2) options:

  - Enrolling for EFT payments automatically removes you from ZPN payments. To receive EFT payments instead of ZPN payments, enroll for EFT through EnrollSafe at **enrollsafe.payeehub.org**.

    OR

  - To disenroll from ZPN payments, update your Zelis registration on the Zelis provider portal or contact Zelis at **877-828-8770**.

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

PCP Access and Availability

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

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

Appointment Type	Appointment Standard
Emergent or emergency visits	Immediately upon presentation
Urgent visits	Within 24 hours of request or sooner as clinically indicated
Nonurgent symptomatic visits	Within 48 to 72 hours of request or sooner as clinically indicated
Routine nonurgent, preventive appointments	Within four weeks of request or sooner, as clinically indicated
Specialist referrals (not urgent)	Within four to six weeks of request
Adult baseline, routine physicals	Within 12 weeks from enrollment
Well-child care visit	Within four weeks of request
Initial family planning visit	Within two weeks of request
Pursuant to an emergency or hospital discharge, mental health or substance follow-up visits with a participating provider (as included in the benefit package)	Within five days of request or as clinically indicated
Nonurgent mental health or substance use visits with a participating provider (as included in the benefit package)	Within two weeks of request
Initial PCP office visit for newborns	Within two weeks of hospital discharge
Provider visits to make health, mental health and substance use assessments for the purpose of making recommendations regarding a recipient's ability to perform work when requested by a LDSS	Within 10 days of request by an Anthem member

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

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

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

Note: For appointment and availability standards for behavioral health services, refer to the Behavioral Health Services chapter.

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

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

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

- Have the office telephones answered after-hours by an answering service, which can contact the PCP or another designated network medical practitioner. Have the office telephone answered after normal business hours by a recording in the language of each of the major population groups served by the PCP, directing the member to call another number to reach the PCP, or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone; another recording is not acceptable.
- Have the office telephone transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or a designated Anthem network medical practitioner.

The following telephone answering procedures are not acceptable:

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

Appointment Access and Availability Studies

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

Anthem always studies and records the results of the study at the end of the call. A passing score denotes that the office has met or exceeded the standard for a particular appointment type or after-hours coverage. In the event a provider fails to meet the established guidelines at the time of the study (meaning the appointment was not scheduled within the prescribed time), Anthem issues a written notice.

The notice requests a written explanation of the provider's policy on 24-hour coverage and appointment availability, as well as a plan of correction addressing the specific measure(s) failed. Anthem reviews the correction plan and resurveys the provider for compliance within two months. If a provider is found to be noncompliant on the second survey, the provider's panel is immediately closed to new members. A plan of correction is requested, and a third survey is conducted. Failure of the third compliance survey results in the immediate termination of the provider.

PCP Panel Capacity

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

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

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

Member Missed Appointments
Anthem members may sometimes cancel or not appear for necessary appointments and fail to reschedule the appointment. This can be detrimental to their health. Anthem requires providers to attempt to contact members who have not shown up for or canceled an appointment without rescheduling the appointment. The contact must be by telephone and should be designed to educate the member about the importance of keeping appointments and to encourage the member to reschedule the appointment.

Anthem members who frequently cancel or fail to show up for an appointment without rescheduling the appointment may need additional education in appropriate methods of accessing care. In these cases, please call your Provider Relations representative. Anthem staff will contact the member and provide more extensive education and/or case management as appropriate. Our goal is for members to recognize the importance of maintaining preventive health visits and to adhere to a plan of care recommended by their PCP.

Noncompliant Anthem Members

Anthem recognizes providers may need help in managing nonadherent members. If you have an issue with a member regarding behavior, treatment cooperation and/or completion of treatment and/or making or appearing for appointments, please contact Provider Services at **800-450-8753**.

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

PCP Transfers

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

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

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

Continuity of Care (Provider Termination)

Continuity of care (provider termination) applies in its entirety to all programs including CHPlus, Medicaid Managed Care products, and Anthem MLTC/MAP.

If a provider leaves the network for reasons other than a determination of fraud, imminent harm to patient care or a final disciplinary action by a state licensing board that impairs the health professional's

ability to practice, Anthem will permit a member to continue an ongoing course of treatment with that provider under the following circumstances:

- If the member has a life-threatening, disabling or degenerative condition, a rare disease, or is in an ongoing course of treatment, they may see the provider for 90 days from when the provider's contract expires.
- If the member is in the second or third trimester of pregnancy, she may see the provider for all prenatal, delivery and postpartum care directly related to the pregnancy.

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

Anthem will immediately remove any provider from the network who is unable to provide healthcare services due to final disciplinary action. Medicaid Managed Care providers who are sanctioned by the DOH's Medicaid Program will be excluded from participation in the Anthem panel.

Transitional Care

As per **Section 15.6** of the *NYS Medicaid/Family Health Plus Managed Care Contract*, Anthem is responsible for authorization and payment of out-of-network services under the following circumstances:

1) For new Anthem members, a transition period of up to 60 days from the enrollment date when the member is in an ongoing course of treatment with an out-of-network provider, and the member has a life-threatening disease or condition or a degenerative and disabling disease or condition. For new members who have entered their second trimester of pregnancy at the effective date of enrollment, there is a transition period of up to 60 days postpartum.
2) For current members, whose provider left Anthem's network for reasons other than imminent harm to member care, a determination of fraud, or a final disciplinary action by state licensing board, there is a transitional period for up to 90 days from the provider's termination date. For pregnant members, the transition period is up to 60 days postpartum.
3) Anthem will authorize transitional care only if:
    a) The out-of-network provider accepts reimbursement from Anthem at rates established as payment in full and no more than the level of reimbursement applicable to similar providers within Anthem's network.
    b) The out-of-network provider agrees to adhere to Anthem's quality assurance requirements and agrees to provide medical information regarding the care.
    c) The out-of-network provider agrees to adhere to Anthem's policies and procedures, including but not limited to procedures regarding referrals and obtaining preauthorization.

Direct Access to OB/GYN, Prenatal, and Obstetrical Care

A new member who has entered her second trimester of pregnancy at enrollment and has an existing relationship with a nonparticipating prenatal care provider may continue to receive care from that provider for a transitional period. The transitional period will include the postpartum care directly related to the delivery up to 60 days postpartum. The provider must agree to accept the Anthem fee schedule and adhere to quality assurance requirements. Precertification is required for these services.

A new Anthem member in her first trimester of pregnancy at enrollment who is seeing a nonparticipating provider for prenatal care may request to continue to see that provider. These cases will be considered on a case-by-case basis.

During the prenatal period, an OB/GYN may function as the PCP. The OB/GYN provider must notify the member's PCP and Anthem's Healthcare Management Services department of any pregnancy. Upon notification of a pregnancy, Anthem's Healthcare Management Services department will register the member in the New Baby, New Life℠ program.

Anthem will encourage members who suspect or confirm a pregnancy to make an appointment with a participating OB/GYN provider as soon as possible. Anthem's Healthcare Management Services department will review and authorize continuity of care for new members who are pregnant and want to continue care with a nonparticipating provider.

Covering Physicians

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

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

In addition, the covering provider will agree to the terms and conditions of the Network Provider Agreement, including, without limitation, any applicable limitations on compensation, billing, and participation. Providers will be solely responsible for a non-network provider's adherence to such provisions. Providers will be solely responsible for any fees or monies due and owed to any non-network provider providing substitute coverage to a member on the provider's behalf.

Specialists as PCPs

Under certain circumstances, when a member requires the regular care of a specialist, a specialist may be approved by Anthem to serve as a member's PCP. The criteria for a specialist to serve as a member's PCP include the member having a chronic, life-threatening illness or condition of such complexity whereby:

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

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

The referral must be approved by Anthem and will be made pursuant to an approved treatment plan approved by Anthem, the member's PCP and nonparticipating physician. The member may not use a nonparticipating specialist unless there is no specialist in the network that can provide the requested treatment. Services are provided to the member at the same cost as if they received the services from an in-network provider. Specialists serving as PCPs will continue to be paid FFS while serving as the member's PCP. The designation cannot be retroactive. For further information, see the Specialist as PCP Request form located in the Appendix A — Forms section of this manual.

Members may self-refer for unlimited behavioral health and substance use assessments (except for Assertive Community Treatment [ACT], inpatient psychiatric hospitalization, partial hospitalization, and HCBS services). Visits for behavioral health services are coordinated by calling **800-450-8753**. A provider or hospital must be contracted with Anthem to provide these services; precertification is not required for behavioral health services when provided by a network provider.

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

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

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

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

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

Specialty Care Center Referrals
Anthem will authorize members with either a life-threatening or a degenerative and disabling condition/disease, which requires prolonged specialized medical care, to receive a referral to an accredited or designated specialty care center with expertise in treating the life-threatening or degenerative and disabling disease/condition.

Second Opinions
A member, parent and/or legally appointed representative or the member's PCP may request a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or

other treatment of a health condition. The second opinion will be provided at no cost to the member.

The second opinion must be obtained from a network provider (see Provider Referral Directory) or a non-network provider, if there is no network provider with the expertise required for the condition. Authorization is required only if the provider is out of network. The PCP will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. The PCP will notify the member of the outcome of the second opinion.

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

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

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

Specialty Care Providers

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

Anthem contracts with a network of provider specialty types to meet the medical specialty needs of members and provide all medically necessary covered services. The specialty care provider is a network physician who is responsible for providing specialized care for members, usually upon appropriate referral from a PCP within the network. (See the Role and Responsibility of the Specialty Care Provider section of this manual for more information.) In addition to sharing many of the same responsibilities to members as PCPs (see Responsibilities of the PCP section), the specialty care provider offers services that include:

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

Role and Responsibilities of the Specialty Care Provider

Specialist providers will only treat members who have been referred to them by network PCPs (with the exception of mental health and substance use providers and services for which the member may self-refer) and will render covered services only to the extent and duration indicated on the referral. Obligations of the specialists include but are not limited to:

- Complying with all applicable statutory and regulatory requirements of the Medicaid program.
- Accepting all members referred to them.
- Submitting required claims information to Anthem, including source of referral and referral number.
- Arranging for coverage with network providers while off-duty or on vacation.
- Verifying member eligibility and precertification of services (if required) at each visit.
- Providing consultation summaries or appropriate periodic progress notes to the member's PCP on a timely basis following a referral or routinely scheduled consultative visit.
- Notifying the member's PCP when scheduling a hospital admission or scheduling any procedure requiring the PCP's approval.
- Coordinating care, as appropriate, with other providers involved in providing care for members, especially in cases where there are medical and behavioral health comorbidities or co-occurring mental health and substance use disorders.

The specialist shall:

- Manage the medical and healthcare needs of members, including monitoring and following up on care provided by other providers, including those engaged on an FFS basis; provide coordination necessary for referrals to other specialists and FFS providers (both in and out of network); and maintain a medical record of all services rendered by the specialist and other providers.
- Provide 24-hour-a-day, 7-day-a-week coverage and maintain regular hours of operation that are clearly defined and communicated to members.
- Provide services ethically and legally, in a culturally competent manner and meet the unique needs of members with special healthcare requirements.
- Participate in the systems established by Anthem that facilitate the sharing of records, subject to applicable confidentiality and *HIPAA* requirements.
- Participate and cooperate with Anthem in any reasonable internal or external quality assurance, utilization review, continuing education or other similar programs established by Anthem.
- Make reasonable efforts to communicate, coordinate and collaborate with other specialty care providers, including behavioral health providers, involved in delivering care and services to consumers.
- Participate in and cooperate with the Anthem complaint and grievance processes and procedures (Anthem will notify the specialist of any member grievance brought against the specialist).
- Not balance bill members.
- Continue care in progress during and after termination of their contract for up to 90 days until a continuity of care plan is in place to transition the member to another provider or through 60 days postpartum care for pregnant members in accordance with applicable state laws and regulations.
- Comply with all applicable federal and state laws regarding the confidentiality of patient records.

- Develop and have an exposure control plan regarding blood-borne pathogens in compliance with Occupational Safety and Health Administration (OSHA) standards.
- Make best efforts to fulfill the obligations under the ADA applicable to their practice location
- Support, cooperate, and comply with the Anthem Quality Improvement Program initiatives and any related policies and procedures designed to provide quality care in a cost-effective and reasonable manner.
- Inform Anthem if a member objects for religious reasons to the provision of any counseling, treatment, or referral services
- Treat all members with respect and dignity.
- Provide members with appropriate privacy and treat member disclosures and records confidentially, giving the members the opportunity to approve or refuse their release as allowed under applicable laws and regulations.
- Provide members complete information concerning their diagnosis, evaluation, treatment, and prognosis, and give members the opportunity to participate in decisions involving their healthcare, except when contraindicated for medical reasons, the information will be made available to an appropriate person acting on the member's behalf.
- Advise members about their health status, medical care, or treatment options, regardless of whether benefits for such care are provided under the program and advise members on treatments that may be self-administered.
- When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings.
- Have a policy and procedure to ensure proper identification, handling, transport, treatment, and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.
- Agree to maintain communication with the appropriate agencies such as local police, social services agencies, and poison control centers to provide quality patient care.
- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention that is part of a clinical research study is clearly distinguished from entries pertaining to non-research-related care.

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

Specialty Care Providers' Access and Availability

Anthem will maintain a specialty network to ensure access and availability to specialists for all members. A provider is considered a specialist if they have a provider agreement with Anthem to provide specialty services to members.

Specialists must adhere to the following access guidelines:

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

Note: For appointment and availability standards for behavioral health services, refer to the Behavioral Health Services chapter.

Obstetrical and/or Gynecological Providers

Obstetrical and/or gynecological (OB-GYN) providers may be any obstetrician, gynecologist, certified nurse midwife or family practitioner with training in obstetrics and gynecology who has been credentialed by Anthem to provide OB-GYN services. While an OB-GYN provider is not a PCP, members may choose to have an OB-GYN provider as their primary source of care. Members can access an OB-GYN provider for their reproductive health needs without a referral from their PCP.
All female members are eligible to receive two well-woman examinations each calendar year from the member's provider of choice within the Anthem network, treatment for acute gynecological conditions, follow-up services related to these primary and preventive services and pregnancy-related care without a referral from their PCP. The OB-GYN must notify the member's PCP of the pregnancy and must notify Anthem at **800-450-8753**.

Pregnancy testing and termination of pregnancy are considered care directly related to pregnancy and are therefore accessed directly. Anthem also requires that participating providers comply with the informed consent procedures for hysterectomy and sterilization specified in *42 CFR, Part 441*, *sub-part F* and *18 NYCRR Section 505.14*. OB-GYN providers must also comply with a prenatal care evidence-based standard of practice, such as the American Congress of Obstetricians and Gynecologists (ACOG) practice guidelines.

Risk Assessment
Every pregnant woman shall receive ongoing assessment of both maternal and fetal risk throughout the prenatal period. Such risk assessment shall include, but not be limited to, an analysis of individual characteristics affecting pregnancy, such as genetic, nutritional, psychosocial, historical, and emerging obstetrical/fetal and medical-surgical risk factors. At the time of registration, a standardized written risk assessment shall be conducted using established criteria for determining high-risk pregnancies, based upon generally accepted standards of practice. This risk assessment shall be:

- Reviewed at each visit.
- Formally repeated early in the third trimester.
- Linked to the plan of care and clearly documented in the medical record.
- A development of the care plan and coordination of care.

A care plan which addresses the proper implementation and coordination of all services required by the pregnant woman shall be developed, routinely updated, and implemented jointly by the pregnant woman and her family where mutually agreeable to the woman and all appropriate members of the healthcare team.

Care shall be coordinated to:

- Ensure relevant information is exchanged between the prenatal care provider and other providers or sites of care, including the anticipated birthing site.
- Ensure the pregnant woman and her family, with her consent, have continued access to information resources and are encouraged to participate in decisions involving the scope and nature of care and services being provided.

- Encourage and assist the pregnant woman in obtaining necessary medical, nutritional, psychosocial, drug and substance use services appropriate to her identified needs and provide follow-up to ensure ongoing access to services.
- Provide the pregnant woman with an opportunity to receive prenatal or postpartum home visitation when the woman may derive medical or psychosocial benefit from such visits, which shall identify familial and environmental factors which may produce increased risk to the woman or fetus. The relevant findings shall be incorporated into the care plan and the pregnant woman will be provided or referred for needed services, including:
    - Inpatient care, specialty physician and clinical services which are necessary to ensure a healthy delivery and recovery
    - Genetic services
    - Drug treatment and screening services
    - Dental services
    - Mental health and related social services
    - Emergency room services
    - Home care
    - Pharmaceuticals
    - Transportation
- Provide special tests and services as may be recommended or required by the Commissioner of Health, who shall require such tests and/or services when necessary to protect maternal and/or fetal health. Women shall be provided appropriate medical care, counseling and education based on test results.
- Encourage continuity of care and client follow-up including rescheduling of missed visits throughout the prenatal and postpartum period.

Nutrition Services
Prenatal providers will establish and implement a program of nutrition screening and counseling which includes:

- Individual nutrition risk assessment including screening for specific nutritional risk conditions at the initial prenatal care visit and continuing reassessment as needed.
- Professional nutrition counseling, monitoring and follow-up of all pregnant women at nutritional risk by a nutritionist or registered dietitian.
- Documentation of nutrition assessment, risk status and nutrition care plan in the patient medical record.
- Arrangements for services with funded nutrition programs available in the community including provision for enrollment of all eligible women and infants in the Supplemental Food Program for Women, Infants and Children (WIC), at the initial visit.

Provision of basic nutrition education and counseling for each pregnant woman should include the following topics:

- Appropriate dietary intake and recommended dietary allowances during normal pregnancy
- Appropriate weight gain
- Infant feeding choices including individualized counseling regarding the advantages and disadvantages of breastfeeding

Health Education
Health and childbirth education services are given to each pregnant woman based on an assessment of her individual needs. Appropriate educational materials including video and written information is used.

Culture, language, and health literacy are taken into account, to help ensure the understanding of the information provided. Such services will be provided by professional staff, documented in the medical record, and will include but not be limited to the following:

- Orientation to procedures at prenatal facilities and at the expected site of birth
- Rights and responsibilities of the pregnant woman
- Signs of complications of pregnancy
- Physical activity and exercise during pregnancy
- Avoidance of harmful practices and substances including alcohol, drugs, nonprescribed medications and nicotine
- Sexuality during pregnancy
- Occupational concerns
- Risks of HIV infection and risk reduction behaviors
- Signs of labor
- Labor and delivery process
- Relaxation techniques in labor
- Obstetrical anesthesia and analgesia
- Preparation for parenting, including infant development and care and options for feeding
- The newborn screening program with the distribution of newborn screening educational literature

Family Planning

A psychosocial assessment shall be conducted and shall include:

- Screening for social, economic, psychological, and emotional problems.
- Referral to the local Department of Social Services, community mental health resources, support groups or social/psychological specialists (as appropriate) for the needs of the woman or fetus.

Prenatal Diagnostic and Treatment Services

Prenatal diagnostic and treatment services shall be provided by a qualified physician practicing in accordance with *Article 131* of the NYS Education Law, a licensed midwife practicing in accordance with *Article 140* of the NYS Education Law, a qualified nurse practitioner practicing in accordance with *Article 139* of the NYS Education Law or a registered physician's assistant practicing in accordance with *Part 94* of this Title, *Article 37* of the NYS Public Health Law and *Article 131* of the NYS Education Law. Such services shall meet generally accepted standards of professional patient care and services.

Prenatal diagnostic and treatment services provided include the following:

- An initial comprehensive assessment including history, review of systems and physical examination
- Standard laboratory tests and procedures
- Needed special laboratory tests as indicated by comprehensive assessment and initial or preliminary test findings
- Evaluation of risk
- Discussion of options for treatment, care and technological support expected to be available at the time of labor and delivery, together with the advantages and disadvantages of each option
- Obtaining the pregnant woman's informed choice of mode of treatment, care and technological support expected

- Postpartum counseling, evaluation, and referral to professional care and services, as required, to include preconception counseling as appropriate
- Establishing arrangements for availability of after-hours and emergency consultation and care for pregnant women

The prenatal provider shall develop and implement written agreements with planned sites of delivery which address, at a minimum:

- Prebooking of women for delivery at 34 to 36 weeks gestation for low-risk pregnancies and 26 weeks gestation for high-risk pregnancies
- Arrangements for referral of women and neonates to appropriate alternate care sites for medically indicated care
- Special tests and procedures which may be required
- A plan detailing how hospitalization for medical or obstetrical problems will occur
- Arrangements with facilities for postpartum services
- A system for sharing medical records with the delivery site and for receiving information from referral sources and delivery sites

Prenatal providers will develop and implement written policies and procedures designating the requirements for consultation with a qualified physician or other healthcare specialist when necessitated by specific medical conditions.

Prenatal providers will designate in writing those situations which require the transfer of the primary responsibility for patient care from a primary care professional who is a family practice physician, physician's assistant, licensed midwife, or qualified nurse practitioner to a qualified obstetrician.

HIV Services

The prenatal provider will:

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

Records and Reports

The prenatal provider shall create and maintain records and reports in accordance with this subdivision that are complete, legible, retrievable, and available for review by representatives of the Commissioner of Health upon request. Such records and reports shall include:

- A comprehensive prenatal care record for each pregnant woman which documents the provision of care and services required by this section, and which is maintained in a manner consistent with medical record confidentiality requirements.
- Special reports and data summaries necessary for the Commissioner of Health to evaluate the provider's delivery of prenatal services.

- Program reports including financial, administrative, utilization and patient care data maintained in such a manner as to allow the identification of expenditure, revenue, utilization, and patient care data associated with healthcare provided to prenatal clients.
- Records of all internal quality assurance activities.
- All written policies and procedures required by this section.

Internal Quality Assurance
The prenatal provider shall develop and implement written policies and procedures establishing an internal quality assurance program to identify, evaluate, resolve, and monitor actual and potential problems in patient care. Components of this program shall include, but not be limited to, the following:

- A documented and filed prenatal chart audit performed periodically on a statistically significant number of current prenatal client records
- An annual written summary evaluation of all components of such audits
- A system for determining patient satisfaction and for resolving patient complaints
- A system for developing and recommending corrective actions to resolve identified problems
- A follow-up process to assure that recommendations and plans of correction are implemented and are effective
- Safeguards to prevent the inappropriate breach of patient confidentiality requirements

Postpartum Services
The prenatal provider shall coordinate with the neonatal care provider to arrange for the provision of pediatric care services in accordance with generally accepted standards of practice and patient services. A postpartum visit with a qualified health professional shall be scheduled and conducted between 7 and 84 days after delivery. For the interim between delivery and the postpartum visit, the prenatal provider shall furnish each woman with a means of contacting the provider in case postpartum questions or concerns arise. The postpartum visit shall include, but not be limited to, the following:

- Identifying any medical, psychosocial, nutritional, alcohol treatment and/or drug treatment needs of the mother or infant that are not being met
- Referring the mother or other infant caregiver to resources available for meeting such needs and providing assistance in meeting such needs where appropriate
- Assessing family planning needs and providing advice, services or referral, where indicated
- Providing preconception counseling and encouraging a preconception visit prior to subsequent pregnancies for women who might benefit from such a visit
- Referring infants to preventive and special care services appropriate to their needs
- Advising the mother of the availability of Medicaid eligibility for infants

For specific requirements regarding OB-GYN appointment access scheduling, office waiting time, telephone access after business hours and on-call coverage standards, please see the Specialty Care Providers Access and Availability section of this manual.

Culturally and Linguistically Appropriate Services

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

The U.S. Department of Health and Human Services (HHS) defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families

receiving services, as well as staff members who are providing such services. It is a dynamic, ongoing developmental process requiring long-term commitment. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains that healthcare is defined through a cultural lens for both patients and providers. A person's cultural affiliations can influence:

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

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

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

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

Anthem ensures providers have access to resources to help support delivery of culturally and linguistically appropriate services. Anthem encourages providers to access and utilize the following resources.

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

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

- **Reducing Healthcare Stereotype Threat (HCST):** Helps providers understand HCST and the implications for diverse patients as well as the benefits of reducing HCST to both providers' patients and practices, and how to do so.

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

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

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

Member Records

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

Providers are required to maintain medical records that conform to good professional medical practice and appropriate health management. A permanent medical record will be maintained at the primary care site for every member and be available to the PCP and other providers. Medical records must be kept in accordance with Anthem and state standards as follows.

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

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

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

1. **Patient identification information**: Each page or electronic file in the record must contain the patient's name or patient ID number.

2. **Personal/biographical data**: The record must include age, sex, address, employer, home and work telephone numbers, and marital status.
3. **Date and corroboration**: All entries must be dated with the author identified.
4. **Legibility**: Each record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.
5. **Allergies**: Medication allergies and adverse reactions must be prominently noted on the record. Absence of allergies (No Known Allergies [NKA]) must be noted in an easily recognizable location.
6. **Past medical history** (for patients seen three or more times): Past medical history must be easily identified including serious accidents, operations, and illnesses. For children, the history must include prenatal care of the mother and birth.
7. **Immunizations**: For pediatric records age 13 and under, a completed immunization record or a notation of prior immunization must be recorded, including vaccines and their dates of administration when possible.
8. **Diagnostic information**
9. **Medication information** (includes medication information/instruction to patient)
10. **Identification of current problems**: Significant illnesses, medical and behavioral health conditions, and health maintenance concerns must be identified in the medical record.
11. **Instructions**: The record must include evidence that the patient was provided with basic teaching and instruction regarding physical and/or behavioral health condition.
12. **Smoking/alcohol/substance use**: A notation concerning cigarettes, alcohol, and substance use must be stated if present for patients aged 12 and older. Abbreviations and symbols may be appropriate.
13. **Consultations, referrals, and specialist reports**: Notes from any referrals and consultations must be in the record. Consultation, lab, and X-ray reports filed in the chart must have the ordering physician's initials or other documentation signifying review. Consultation and any abnormal lab and imaging study results must have an explicit notation in the record of follow-up plans.
14. **Emergencies**: All emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions while the patient is part of the PCP's panel must be noted.
15. **Hospital discharge summaries**: Discharge summaries for all hospital admissions that occur while the patient is enrolled and for prior admissions, as appropriate. Prior admissions that may have occurred before the patient was enrolled may be pertinent to the patient's current medical condition.
16. **Advance directive**: For adult patients, record whether or not the individual has executed an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney that directs healthcare decision-making for individuals who are incapacitated.
17. **Security**: Providers must maintain a written policy as required to ensure that medical records are safeguarded against loss, destruction, or unauthorized use. Additionally, a provider must develop policies and procedures for their staff to ensure confidentiality of HIV-related information. The policy and procedure for HIV must include:
    - Initial and annual in-service education of staff and/or contractors
    - Identification of staff allowed access and limits of access
    - Procedures to limit access to trained staff (including contractors)
    - Protocol for secure storage (including electronic storage)
    - Procedures for handling requests for HIV-related information
    - Protocols to protect persons with or suspected of having HIV infection from discrimination.
18. **Release of information**: Written procedures are required for the release of information and obtaining consent for treatment.
19. **Documentation**: Documentation is required setting forth the results of medical, preventive and behavioral health screening, all treatment provided and results of such treatment.

20. **Multidisciplinary teams**: Documentation is required of the team members involved in the multidisciplinary team of a patient needing specialty care.
21. **Integration of clinical care**: Documentation of the integration of clinical care in both the physical and behavioral health records is required. Such documentation must include:
    - Screening for behavioral health conditions (including those which may be affecting physical healthcare and vice versa) and referral to behavioral health providers when problems are indicated.
    - Screening and referral by behavioral health providers to PCPs when appropriate.
    - Receipt of behavioral health referrals from physical medicine providers and the disposition/outcome of those referrals.
    - A summary of the status/progress from the behavioral health provider to the PCP, at least quarterly (or more often if clinically indicated).
    - A written release of information that will permit specific information sharing between providers.
    - Documentation that behavioral health professionals are included in primary and specialty care service teams described in this contract when a patient with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder.
22. **Provider reporting obligations**: Documentation of reasonable efforts to assure timely and accurate compliance with NYC public health reporting requirements in the following areas:
    - Infants and toddlers suspected of having a developmental delay or disability
    - Suspected instances of child abuse
    - Immunization Registry and Blood Lead Registry
    - Communicable disease and conditions mandated in the New York City Health Code, pursuant to *24 RCNY§ 11.03-11.07* and *Article 21* of the NYS Public Health Law

Patient Visit Data

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

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

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

Anthem maintains an appropriate record keeping system for services to members. This system will collect all pertinent information relating to the medical management of each member and make that information readily available to appropriate health professionals and appropriate state agencies. All records will be retained in accordance with the record retention requirements. A member's medical record must be retained by their provider for six years after the date of service rendered to the member, and in the case of a minor, for three years after majority or six years after the date of the service, whichever is later. Prenatal care medical records will be centralized and for all other services.

Clinical Practice Guidelines

Using nationally recognized standards of care, Anthem works with providers to develop clinical policies and guidelines for the care of our membership. The Medical Advisory Committee oversees and directs Anthem in formulating, adopting, and monitoring guidelines.

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

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

Anthem clinical and network staff are available to review these practices and guidelines. These reviews can occur in a group setting, via WebEx or in person.

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

Advance Directives

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

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

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

Members over age 18 and emancipated minors are able to make advance directives. Their response is to be documented in the medical record. Anthem will not discriminate or retaliate based on whether a member has or has not executed an advance directive.

While each member has the right without condition to formulate an advance directive within certain limited circumstances, a facility or an individual physician may conscientiously object to an advance directive.

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

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

9 MEDICAL MANAGEMENT

Medical Review Criteria

Effective **May 1, 2013**, Anthem medical policies, which are publicly accessible from its Anthem subsidiary website, became the primary benefit plan policies for determining whether services are considered to be a) investigational/experimental, b) medically necessary, and c) cosmetic or reconstructive for Anthem subsidiaries.

Effective November 4, 2019, Milliman (MCG) criteria will be used when no specific Anthem medical policies exist. In the absence of licensed Milliman (MCG) criteria, Inter Qual (Mental Health Services - starting September 2022); LOCADTR for Substance Use Services, state criteria adopted by the plan for ACT and other Mental health services, Anthem subsidiaries may use *Anthem Clinical Utilization Management (UM) Guidelines*. A list of the specific Anthem *Clinical UM Guidelines* used will be posted and maintained on the Anthem subsidiary websites and can be obtained in hard copy by written request. The policies described above will support precertification requirements, clinical-appropriateness claims edits and retrospective review.

Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first when determining eligibility for coverage. As such, in all cases, state Medicaid contracts or CMS requirements will supersede both Milliman (MCG) and Anthem medical policy criteria. Medical technology is constantly evolving, and we reserve the right to review and periodically update medical policy and utilization management criteria.

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

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

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

Anthem does not employ utilization controls or other coverage limits to automatically place limits on the length of stay for members requiring hospitalization or surgery. Length of stay for a member's request for hospitalization or surgery is based on the needs of the member rather than on arbitrary limits. Members who are hospitalized or receiving surgical services are managed by an assigned utilization

manager. The clinical review for these services will specify authorization for coverage limits as determined by clinical guidelines and individual needs. Subsequently, the utilization manager working with the hospital, PCP/attending physician and other parties will monitor and continually review the case to determine discharge readiness and to facilitate discharge planning. For members found to require extended benefits, as identified by the concurrent review of individual needs, severity of illness and services being rendered, the utilization manager has the authority to extend the hospital stay or other services as needed.

In the application of criteria, it is generally understood that these criteria are designed for uncomplicated patients and for a complete delivery system. This may not be appropriate for patients with complications or for a delivery system with insufficient alternatives for care. Anthem will consider the following when applying criteria to a given individual:

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

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

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

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

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

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

HCBS Review and Criteria

Health Homes will complete assessments to assess HCBS eligibility. Health Homes are also responsible for completing a comprehensive care plan.

Health Homes and plans will work together to develop a process whereby the Health Home shares results of assessments and care plans with the plan. This can be telephonic, via fax, FTP or other methods that works for both the Health Home and the plan.

If the results of the assessment indicate the member is eligible for HCBS services, the Health Home will contact the plan, and this information will be shared with the plan. As part of the review process, the plan will discuss the assessment to ensure all data elements (health, safety, education, employment, housing, and all other related information) were reviewed and the assessment was comprehensive.

Anthem will also ensure:

- The assessment was completed by a person who meets all required qualifications.
- The initial care plan relates to the findings within the assessment.
- The care plan is person-centered and recovery-focused.

Anthem uses state-approved criteria for adult and children's HCBS services.

For adults, on completion of the state-mandated assessment, the Health Home is expected to give members a choice of at least three providers for the HCBS service. Once linked to the service, the HCBS provider contacts the plan for authorization.

For children, the assessment is used to determine whether the member is eligible for HCBS services and for which type of HCBS service(s). Anthem will review the assessment with the Health Home; ensure it is comprehensive; authorize HCBS services; and inform the HCBS provider, the member and the Health Home.

The dedicated HCBS case manager within HARP or the children's team will review the assessments and care plan and authorize the HCBS service. The HCBS care manager will be the primary contact for services requiring authorization. Ongoing concurrent review will be conducted with the in-network provider to ensure the plan of care is being followed and any barriers are being addressed. If Anthem finds deviations from the plan of care, we will conduct outreach to review them and discuss adjustments to either the service delivery or the plan of care.

To assess if a member is HCBS-eligible, providers should contact Anthem so we can take the steps necessary to refer to the Health Home or other approved entity, and the assessment can be completed to determine HCBS eligibility.

Health Homes/Care Management Agencies are expected to complete a care plan that incorporates the HCBS service(s) and submit it to us for approval.

HCBS providers are expected to contact Anthem for authorizations a few days before the 60-day/96-unit/24-hour period is coming due. Providers can contact the plan via phone, fax, or ICR to share assessment information. Our dedicated HCBS team within the Children's Services team will review the results of the assessment and eligibility for HCBS service, functioning in an integrated utilization management and care management role. While this team authorizes services based on the HCBS criteria that are state-developed and adopted by Anthem, its role is to ensure:

- The assessments are complete and comprehensive.
- HCBS services are recovery-focused and person-centered.

- The care plans include the HCBS service(s) and all other needed services the member requests at the care plan meeting.
- There is an exchange of information between Anthem, the Health Home, and the HCBS provider to effectively support the member.

Providers can contact the plan via phone, fax, or ICR to request authorizations for HCBS services.

Our HCBS team reviews the authorization request form and the care plan to ensure:

- The HCBS service assessment ties to the goals.
- The care plan is person-centered to reflect the member's self-efficacy and personal values, choices, and goals.
- The care plan is comprehensive.
- All applicable individuals, including the member, guardian(s), family member(s), and provider(s), have been consulted and agree to the type, scope, and duration of the services listed within the plan.
- The care plan is inclusive of a member's strengths and barriers, includes support systems to help the member achieve their goals, and is written in a way that is understandable to the member and/or family/guardian.
- The care plan is compliant with federal regulations and state guidance.

The HCBS service is then authorized. We enter this authorization into our utilization management system, and the details of the service plan are documented in our care management system.

Please note: HCBS are managed in compliance with the CMS HCBS Final Rule and all applicable state guidance.

Authorization Request Process

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

Utilization Review Delegation
Anthem may delegate utilization review (UR) activities for select services to an approved, accredited UR agent.

In those instances, providers should refer to the provider web portal to confirm the appropriate agent and contact information to initiate the authorization request process. All delegated agents follow the Anthem UR processing guidelines, including time frames and notification for authorization, in adherence with the state Medicaid contract.

Notification
Notification is defined as the requirement for the provider to notify Anthem by telephone or fax of the intent to render covered medical services to a member. Member eligibility and provider status (participating and nonparticipating) are verified. Notifications can be called in to **800-474-3530** or faxed to **800-964-3627**.

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

Precertification
Precertification is the prospective process whereby licensed clinical associates apply designated criteria sets against the intensity of services to be rendered, a member's severity of illness, medical history, and previous treatment to determine the medical necessity and appropriateness of a given coverage request.

Prospective means the coverage request occurred prior to the service being provided. Medically necessary care is defined as services and supplies which are necessary to prevent, diagnose, correct, or cure conditions in an individual that cause acute suffering, endanger life, result in illness or infirmity, interfere with such a person's capacity for normal activity, or threaten some significant handicap. Precertification requests can be submitted by phone at **800-450-8753**, via fax to **800-964-3627** or via our website at **https://providers.anthem.com/ny**. In the case of a standard or nonexpedited request, a decision and notification will be made within three business days of receipt of the necessary information but no later than 14 days after the receipt of the request.

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

Concurrent Review
A concurrent review is the review of a request for continued, extended or more of an authorized service than what is currently authorized by Anthem. Concurrent review requests can be submitted by phone at **800-450-8753**, via fax to **800-964-3627** or via our website at **https://providers.anthem.com/ny**. In the case of a standard, nonurgent concurrent review, a decision and notification will be made within one business day of receipt of the necessary information but no more than 14 days after receipt of the request. Expedited review of a concurrent review request must be conducted when Anthem or the provider indicate the delay would seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum functions. Members have the right to request an expedited review, but Anthem may deny and notify the member the review will be processed under standard review time frames. In the case of an expedited concurrent review, a decision and notification will be made within one business day of receipt of the necessary information, but no more than 72 hours after the receipt of

the request. Notice of determination shall include the number of continued or extended services approved, the new total of approved services, the date of onset of services and the next review date.

In cases of requests for home healthcare services following an inpatient hospital admission, notice of determination must be sent within 72 hours after receipt of the necessary information.

Retrospective Review
A retrospective review is the review of a request for services already rendered. Retrospective reviews will be processed by the claims department for services that were not precertified. A decision will be made within 24 hours of receipt of the necessary information, but no more than 30 days after receipt of the request. Notification will be mailed to the member on the date of a payment denial, in whole or in part.

Retrospective Review of Preauthorized Services
Anthem may reverse a preauthorized treatment, service, or procedure when and if:

- Relevant medical information presented to Anthem or the Utilization Review (UR) agent upon retrospective review is materially different from the information that was presented during the precertification review, and;
- Information existed at the time of the precertification review but was withheld or not made available, and;
- Anthem or the UR agent was not aware of the existence of the information at the time of the precertification review, and;
- Anthem *had* been aware of the information, the treatment, service or procedure being requested would not have been authorized.

Extension of expedited and standard review time frames for precertification and concurrent review requests may occur if the member, member's designee, or provider requests an extension; or Anthem can demonstrate a need for more information and the extension is in the member's best interest. An extension will extend the review turnaround time by 14 calendar days. An extension notification will be mailed to the member and provider. Failure to meet the service authorization request time frames as noted above is deemed to be an adverse determination subject to appeal. Anthem must send a notice of denial on the date the review time frames expire.

Table 1. Standard Time Frames for Completion of Authorization Requests for UM Decision Making and Notification (including behavioral health and non-behavioral health)

Type of Request	Decision and Electronic/Written Notification NCQA Standard Time Frame	NYS *Article 49* Regulatory Notification Time Frame *(§ 4903* UR Determinations)
Preservice/Prospective		
Urgent	Within 72 hours (three calendar days) from receipt of request	As fast as the enrollee's condition requires, but no more than 72 hours from the request date. Notice is sent to the enrollee and provider by phone and in writing.*
Nonurgent	Within 14 calendar days from receipt of request	Within three (3) business days of receipt of the necessary information but no more than 14 days after receipt of the service.* Notice is sent to the enrollee and provider by phone and in writing.

Concurrent		
Urgent	Within 24 hours (one calendar day) from receipt of request extended to 72 hours (three calendar days) when additional clinical information is requested	As fast as the enrollee's condition requires and no more than 72 hours from the request date (three calendar days). Notice is sent to the enrollee and provider by phone and in writing.*
Nonurgent	N/A	Within one (1) business day of receipt of the necessary information but no more than 14 days after receipt of the services authorization request if an extension letter was sent. Notice is sent to the enrollee and provider by phone and in writing.*
Home care after inpatient stay	N/A	One business day after all info; no more than 72 hours*
Home care after inpatient stay if next day Friday/holiday	N/A	As fast as the enrollee's condition requires, but no more than 72 hours from the request date. Notice is sent to the enrollee and provider by phone and in writing.*
Reductions, Terminations, Suspensions	N/A	Notice at least 10 days in advance with exceptions. (FH/aid continuing applies)
Post-service/Retrospective		
N/A	Within 30 calendar days from receipt of request	Within 30 calendar days from receipt of the necessary information.
Post-stabilization Care Services (Emergency Care)		
N/A	Within one hour of a request for preapproval of further care to maintain the stabilized condition, or under certain conditions, to improve or resolve the stabilized condition	N/A

*The timeframe may be extended by up to 14 calendar days.

Table 2. NCQA Extension Time Frames for Completion of Authorization Requests Lacking Necessary Information (including Behavioral Health and Nonbehavioral Health UM)

Type of Request	Frequency	Decision and Electronic/Written Notification Extension Time Frame
Lack of necessary information or matters beyond control of Anthem		
Urgent, Concurrent	Once: • Request not made at least 24 hours to expiration • Request to approve additional days for urgent, concurrent care is related to care not previously approved, and at least one attempt was made to obtain additional info within initial 24 hours of request • Member voluntarily agrees to extend the decision-making time frame	Within 72 hours (three calendar days) from receipt of request

Urgent, Preservice	Once: • Must give notification within 24 hours of what specific information is needed • Must give 48 hours to provide the information	Within 48 hours of receiving the information or within 48 hours of the expiration of the specified time period to provide the information
Nonurgent, Preservice	Once	Within 14 calendar days of receiving information
Post service/Retrospective	Once	Within 14 calendar days of receiving information

In the event we're unable to make a nonurgent preservice or post service decision due to matters beyond our control, or due to the lack of necessary information, we may extend the decision time frame once if we notify the member or member's authorized representative within:

- Fourteen (14) calendar days of a preservice request; **or**
- Thirty (30) calendar days of a post-service request, including date by which we expect to make a decision

In accordance with the New York State Medicaid contract, time frames for preservice and concurrent review determination for both standard and expedited request may be extended for up to 14 days if:

- The enrollee, the enrollee's designee, or the provider request an extension orally or in writing; **or**
- We demonstrate or substantiate there is a need for additional information and the extension is in the member's best interest. We will ensure there is supportive documentation to demonstrate justification for the extension and that it is made available upon NYSDOH request.

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

Adverse Determination

An adverse determination is the denial of a service authorization request or the approval of a service authorization request in an amount, duration or scope that is less than what was requested. Adverse determination decisions are made by a clinical peer reviewer whose credential is at least equal to that of the recommending clinician.

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

- A description of the action taken or to be taken.
- The reason for the decision, including any clinical rationale.
- The member's right to file an internal appeal including a statement that Anthem will not retaliate or take discriminatory action against a member if an appeal is filed and a statement that the member has the right to designate someone to file an appeal on their behalf.
- The process and timeframe for filing an appeal, including an explanation that an expedited review can be requested.
- A description of what additional information, if any, must be obtained by Anthem in order to make a decision on an appeal.
- The timeframes, including possible extensions of when the appeal decision must be made.
- The notice entitled *Managed Care Action Taken* for denial of benefits or for termination or reduction in benefits, as applicable, containing the member's fair hearing and aid continuing rights (for Medicaid members only).

- Notice of the availability, upon request by the member or member's designee to obtain the review criteria or benefit provision used to make the decision.
- Specification of what, if any, additional information must be provided to or obtained by Anthem to make a decision on an appeal.
- Appeals will be reviewed by a person not involved in the initial determination.
- The member's right to contact the NYSDOH at **800-206-8125** to file a complaint at any time.
- A fair hearing notice including aid to continue rights if applicable.
- Statement that the notice is available in other languages and formats for special needs and how to access these formats.

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

Peer-to-Peer Review
If a request for authorization results in an adverse determination, the servicing/treating provider may discuss the decision with the physician reviewer. The reviewer will have clinical experience relevant to the adverse determination (for example, a denial of rehabilitation services will be made by a clinician with experience providing such service, or at least in consultation with such a clinician, and a denial of specialized care for a child would not be made by a geriatric specialist).

To arrange such a review, providers can call **800-454-3730** or **212-563-5570, ext. 1062001261, option 1** prior to the timeframe of an appeal expires.

Appeals
For Medicaid Managed Care, a member or a member's designee has 60 calendar days from the date of the notice of action to file an internal appeal. For Child Health Plus, a member or a member's designee has 60 days from the date of the notice of action to file an internal appeal. In cases of retrospective services, a provider may file an appeal on their own behalf. An appeal may be filed verbally by calling Member Services at **800-300-8181**, online via the authorization application accessed through Availity Essentials at **https://Availity.com**, or in writing to:

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

Appeals must be received by the health plan within the 60-day timeframe.

If assistance is needed to file an appeal, we can help. Please call:
- Member Services: **800-300-8181**
- Provider Services: **800-450-8753**

A provider appealing on the behalf of members must submit written proof of member consent to act on their behalf. A provider filing an appeal on their own behalf does not exhaust the member's right to appeal.

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

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

- Denial for concurrent services or denial of an extension for concurrent services
- Denial for services that are part of a specific treatment plan as prescribed by the member's physician
- Denial of a hospital admission while the member is still in-house at the time of the denial
- Denial of home care services following an admission to the hospital
- Denial of services that the member or member's physician feel are urgent, and a delay in review would jeopardize the member's life, health, or the ability to attain, maintain, or regain maximum function

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

An expedited appeal decision will be made as fast as the member's condition requires and within 72 hours of receipt of the necessary information for Medicaid Managed Care, and within two business days of receipt of the necessary information for Child Health Plus. A member may be eligible to file an external expedited appeal at the same time while filing the internal appeal with the health plan. Written notification of an expedited appeal decision will be sent within 24 hours of rendering the decision. Anthem will make a reasonable effort to provide oral notice to the member and the provider at the time the decision is made.

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

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

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

- The date, basis, and clinical rationale for the decision.
- The words **final adverse determination**.
- The member's coverage type.
- The UR agent's name, address, contact person, and phone number.
- The service that was denied, including facility/provider and developer/manufacturer of service as available.
- A statement that the member may be eligible for an external appeal and the time frames for an external appeal.
- A statement indicating that if a second level of internal appeal is offered, the member cannot be required to exhaust both levels and has only four months from the receipt of the final adverse determination to file an external appeal. Note: Choosing to file for a second level of internal appeal may cause the time frame to file an external appeal to expire (Anthem does not offer a second level of internal appeal).
- The standard description of the external appeal process.
- A summary of appeal and date filed.
- The date appeal process was completed.
- A description of the member's fair hearing rights (if not included with the original denial; CHPlus members do not have fair hearing rights).
- The member's right to contact the NYSDOH at **800-206-8125** and complain
- A statement that the notice is available in other languages and formats for special needs and how to access these formats.

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

In order to comply with both NYS regulatory requirements and NCQA standards, Anthem will follow the most stringent time frames for appeals. See the following table for comparison:

Appeals Standard Time Frames

Appeal Type	Filing an Appeal	Decision Notification: NCQA Time Frames	NYS *Article 49* Regulatory Notification Time Frame (*§ 4903* UR Determinations)
Preservice			
Expedited (Urgent)	ASAP	Within two business days but no more than 72 hours of receipt of the appeal request	For Child Health Plus, clinical peer reviewer must be available within one business day. A determination will be made within two (2) business days of receipt of necessary information but no longer than 72 hours of appeal request. If time frame is not adhered to,

Appeal Type	Filing an Appeal	Decision Notification: NCQA Time Frames	NYS *Article 49* Regulatory Notification Time Frame (*§ 4903* UR Determinations)
			automatic approval is granted. Final adverse determination notification is transmitted to the enrollee/enrollee's designee and provider within 24 hours of determination. For Medicaid Managed Care, a determination will be made within 72 hours.
Standard	For Medicaid; 60 calendar days from the date of the notice of action. For Child Health Plus/Essential Plan: 180 days from the date of the notice of action	Within 30 calendar days of receipt of the appeal request	Acknowledgment letter to appealing party is sent within 15 days of filing. Enrollee and provider are notified if additional information is needed. If partial information is received, Anthem will request missing information in writing within five (5) business days of receipt of partial information. A different peer clinical reviewer makes the determination no later than 30 days from the date of the appeal request. If time frames are not adhered to, automatic approval is granted. Final adverse determination notice is sent to enrollee/enrollee's designee and provider within two (2) business days of the decision.
Retrospective/post-service			
N/A	For Medicaid; 60 calendar days from the date of the notice of action. For Child Health Plus/Essential Plan: 180 days from the date of the notice of action	Within 30 calendar days of receipt of the appeal request	Same as standard time frame

External Appeal Process

As the provider, you may be eligible to request an external appeal, an independent review of a coverage denial made by a third-party agent known as an External Review agent. You may request an external appeal if one of the following applies:

- The denial issued was based upon lack of medical necessity and the member has exhausted the internal action appeal process through Anthem, or the member and Anthem both agree to waive the internal action appeal process.
- The denial was issued because the service is considered experimental or investigational and the member has exhausted the internal action appeal process through Anthem or the member and Anthem both agree to waive the internal action appeal process. In this case, a physician must certify that the member has a life-threatening or disabling disease or condition or a rare disease for which:

    - Standard medical treatment is not effective or medically inappropriate.
    - Standard medical treatment does not exist.
    - A licensed, board-certified, or board-eligible doctor recommends either:
        - A treatment or medication which, based on two documents of medical and scientific evidence, is likely to be more beneficial to the member than any covered standard treatment.
        - In the case of a rare disease, a treatment whose benefits to the member outweigh the risks.
        - In the case of a rare disease, a clinical trial for which the member is eligible.
- The denial was issued because the service is being done by an out-of-network provider (outside of the Anthem network) and the member has exhausted the internal action appeal process through Anthem, or the member and Anthem both agree to waive the internal action appeal process. In this case, a physician must certify that:
    - The out-of-network service is materially different than the recommended in-network service.
    - A licensed, board-certified, or board-eligible doctor recommends an out-of-network treatment or medication which, based on two documents of medical and scientific evidence, is likely to be more beneficial to the member than any covered in-network treatment and whose benefits to the member outweigh the risks.

Providers may request an external appeal no later than 60 days from the date of the final adverse determination. A member has up to four months to request an external appeal.

Please note that in cases concerning ongoing (concurrent) services or services already provided to the member (retrospective), you may be eligible to request an external appeal on the member's behalf.

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

- Services are essential to prevent, diagnose, manage, or treat conditions that cause acute suffering, endanger life, result in illness or infirmity, interfere with the capacity for normal activity, or threaten some significant handicap.
- For children and youth, services are necessary to promote normal growth and development and prevent, diagnose, treat, ameliorate, or palliate the effects of a physical, mental, behavioral, genetic, or congenital condition, injury, or disability.
- Services prevent the worsening of, alleviate, correct, or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, result in illness or infirmity of a member, or interfere with such person's capacity for normal activity.
- Services are provided at an appropriate facility and at the appropriate level of care for the treatment of the member's medical condition.
- Services are provided in accordance with generally accepted standards of medical practice.

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

Fair Hearing Process

A member or their designee may ask for a fair hearing and/or an external appeal. However, the decision of the fair hearing officer will supersede any external appeal decision. A member or their designee can request a fair hearing by sending a written request within 120 days from the final adverse determination to:

New York State Office of Temporary and Disability Assistance
Fair Hearings
P.O. Box 22023
Albany, NY 12201-2023

Or by phone toll-free at **800-342-3334** or by fax at **518-473-6735**.

Continuation of Benefits (Aid Continuing)

Anthem members may request a continuation of their benefits during the appeal process by contacting Anthem Member Services at **800-300-8181**. To ensure continuation of currently authorized services, the member or person acting on behalf of the member must file a medical appeal on or before 10 days following Anthem mailing the notice of action, or the intended effective date of the action.

The member has the right to aid continuing (AC) in the following circumstances:

- Anthem makes a determination to terminate, suspend, or reduce a previously authorized service during the period for which the service was approved.
- For a member receiving long-term services and support or nursing home services (short- or long-term): Anthem makes a determination to partially approve, terminate, suspend, or reduce the level or quantity of long-term services and supports or a nursing home stay (long-term or short-term) for a subsequent authorization period of such services.

Anthem will continue the member's services provided under AC until one of the following occurs:

- The member withdraws the request for AC, the plan appeal, or the fair hearing.
- The member fails to request a fair hearing within 10 days of Anthem's written adverse appeal resolution notice (final adverse determination).
- The Office of Administrative Hearings determines the member is not entitled to AC.
- The Office of Administrative Hearings completes the administrative process and/or issues a fair hearing decision adverse to the member.
- The provider order has expired (except in the case of a homebound member).

The member may be responsible for the continued benefits if the final determination of the appeal is not in the member's favor. If the final determination of the medical appeal is in the member's favor, Anthem will authorize coverage of and arrange for disputed services promptly and as expeditiously as the member's health condition requires. If the final determination is in the member's favor and the member received the disputed services, Anthem will pay for those services.

10 HOSPITAL AND ELECTIVE ADMISSION MANAGEMENT

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

Requests for precertification with all supporting documentation must be submitted at a minimum of 72 hours prior to the scheduled admission. Failure to comply with notification rules will result in an administrative denial.

Administrative Denial
Administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials occur when a contractual requirement is not met, lack of precertification or failure by the provider to submit clinical when requested. Appeals for administrative denials must address the reason for the denial (in other words, why precertification was not obtained or why clinical was not submitted).

If Anthem overturns its administrative decision, the case will be reviewed for medical necessity, and if approved, the claim will be reprocessed or the requestor will be notified of the action that needs to be taken.

This will allow Anthem to verify benefits and process the precertification request. For services that require precertification, Anthem makes case-by-case determinations that consider the individuals' healthcare needs and medical histories in conjunction with InterQual criteria.

The hospital can confirm that an authorization is on file by calling **800-450-8753** (see Section 14 of this manual for instructions). If coverage of an admission has not been approved, the facility should call Anthem at **800-450-8753**. Anthem will contact the referring physician directly to resolve the issue.

Anthem is available 24 hours a day, 7 days a week to accept precertification requests. When a request is received from the physician via telephone or fax for medical services, the Care Specialist will verify eligibility and benefits. This information will be forwarded to the precertification nurse.

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

When the clinical information received is in accordance with the definition of medical necessity and in conjunction with InterQual criteria/MCG Criteria/Elevance Health Clinical Guidelines/ Elevance Health Medical Policies, an Anthem reference number will be issued to the referring physician. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member's needs and medical history.

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

If the medical director denies coverage of the request based on medical necessity, provider would be afforded an opportunity for Peer to Peer or a Reconsideration. The appropriate denial letter (including the member's appeal rights) will be mailed to the requesting provider, the member's PCP, and the member.

Emergent Admission Notification Requirements

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

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

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

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

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

Nonemergent Outpatient and Ancillary Services: Precertification/Notification Requirements

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

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

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

Precertification and Notification Requirement Guidelines

Service	Requirement	Comments
Behavioral health/substance use	Notification required and subsequent concurrent reviews – for details refer to quick reference guide	• Inpatient psychiatric, inpatient detoxification, inpatient substance use rehabilitation • Precertification is required for coverage of psychological and neuropsychological testing. • Partial hospitalization • Rehabilitation services for residential SUD treatment supports (OASAS service): o Continuing day treatment o PROS o ACT o Psychosocial Rehabilitation o Community Psychiatric Support and Treatment (CPST) o Crisis Intervention o Peer Supports o Habilitation o Residential Supports in Community Setting o Short-term crisis respite o Intensive crisis respite o Non-Medical transportation o Family Support and training o Employment Supports including: ▪ Pre-vocational ▪ Transitional employment ▪ Intensive supported employment ▪ On-going supported educational support services o Supports for self-directed care including: ▪ Information and assistance in support of participation direction ▪ Financial management services
Biofeedback	Precertification	Precertification is required.
Point-of-care blood lead testing		Covered for pregnant women and children 6 years and younger. Physician office laboratories and limited-service laboratories must bill for in-office testing using CPT-4 procedure code 83655.
Cardiac rehabilitation	Precertification	Precertification is required.
Chemotherapy		No precertification is required for outpatient chemotherapy services when performed in a participating facility, provider's office, or ambulatory surgery center. Precertification is required for coverage of inpatient chemotherapy services and for certain chemotherapy drugs. For information on coverage of chemotherapy drugs, please see the Pharmacy section of this grid.
Chiropractic services		Chiropractic is not a covered service for adults. This is a covered benefit under the FFS Medicaid program for children under the age of 21 as part of the EPSDT program, and only when ordered by a physician.
Clinical trials		• **Medicaid Managed Care members**: Experimental and investigational treatment is covered on a case-by-case basis. • **CHPlus members**: This is not a covered benefit.

Service	Requirement	Comments
Court-ordered services	Precertification	Precertification is required.
Dental services		• Members may self-refer for dental checkups and cleaning exams. Dental benefits are administered through a network vendor, LIBERTY Dental Plan. Dental procedures requiring anesthesia and/or planned inpatient admission or services at an outpatient ambulatory center must first be approved by LIBERTY. If approved, a follow-up call to Anthem is required by the provider for precertification. For TMJ services, see the *Plastic/cosmetic/reconstructive surgery* section of this grid. • Orthodontic care is covered for Medicaid Managed Care members. See the *Orthodontic care* section of this grid. • **Medicaid Managed Care members**: Managed care members may self-refer to Article 28 clinics not in our network operated by academic dental centers to obtain covered dental services. Also includes up to four annual fluoride varnish treatments for children from birth until age 7 years when applied by a dentist, physician, or nurse practitioner. • **CHPlus members**: All necessary procedures requiring dental anesthesia for simple extractions and other routine dental surgery that do not require hospitalization are covered and include in-office conscious sedation. • Providers may call LIBERTY at **888-352-7924** for the following: o Emergency Referral Unit o Provider Services Unit o Provider Relations
Dermatology services	No precertification required for network provider for E&M, testing and procedures	Services considered cosmetic in nature are not covered. Services related to previous cosmetic procedures are not covered. See the *Diagnostic testing* section of this grid.
Diagnostic testing	Precertification	• No precertification is required for routine diagnostic testing. • Precertification is required for coverage of MRA, MRI, CAT scans, nuclear cardiac, PET scans, and video EEG. • Contact Carelon Medical Benefits Management at **800-714-0040**.
Durable medical equipment	Precertification and certificate of medical necessity	• Durable medical equipment (DME) are devices and equipment that can withstand repeated use for a protracted period of time; is primarily and customarily used for medical purposes; is generally not useful to a person in the absence of illness or injury; and is usually not fitted, designed or fashioned for a particular individual's use. Where equipment is intended for use by only one person, it may be either custom made or customized. • No precertification is required for coverage of preferred glucometers and nebulizers, dialysis and ESRD equipment, gradient pressure aid, infant photo/light therapy, sphygmomanometers, walkers and orthotics for arch support, heels, lifts, shoe inserts and wedges by network provider. • All DME billed with an RR modifier (rental) requires precertification.

Service	Requirement	Comments
		• Precertification is required for coverage of certain DME. Certain items are considered comfort items and are not covered. For code-specific precertification requirement for DME, please visit our website, go to the *Quick Tools* menu, and select **Prior Authorization Lookup Tool**. • Precertification of DME items costing $1,500 or more require medical director's review. Items costing $3,000 or more require National DME Consultant's review. • Precertification may be requested by completing a Certificate of Medical Necessity (CMN) — available on our website — or by submitting a physician order and *Anthem Referral and Authorization Request* form. A properly completed and physician-signed CMN must accompany each claim for the following services: hospital beds, support surfaces, motorized wheelchairs, manual wheelchairs, Continuous Positive Airway Pressure (CPAP), lymphedema pumps, osteogenesis stimulators, Transcutaneous Electrical Nerve Stimulators (TENS), seat lift mechanisms, Power Operated Vehicles (POVs), external infusion pump, parenteral nutrition, enteral nutrition, and oxygen. Anthem and provider must agree on HCPCS and/or other codes for billing covered services. • See the *Disposable medical supplies* section of this grid for guidelines relating to disposable medical supplies.
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) visit	Self-referral	• Utilize EPSDT schedule and document visits. Vaccine serum is received under the Vaccines for Children (VFC) Program. • **Medicaid Managed Care members**: Chiropractic services are covered for children under age 21 as part of the EPSDT program only when ordered by a physician. • **CHPlus members**: Services are covered according to the medical need and visitation schedules established by the American Academy of Pediatrics. • **Members in foster care:** See the *Members in foster care* section for additional EPSDT considerations.
Educational consultation		No notification or precertification is required.
Emergency room	Self-referral	No notification is required for emergency care given in the ER. If emergency care results in admission, notification to Anthem is required within 24 hours or the next business day. For observation precertification requirements, see the *Observation* section of this grid.
Enteral formula	Precertification	Enteral formula and nutritional supplements are covered under DME benefit and must be obtained through a DME provider rather than a pharmacy for Child Health Plus members. Enteral Formula and nutritional supplements for Medicaid and HARP members located in *Sections 4.1*, *4.2*, and *4.3* of the *New York State Medicaid DME, Prosthetics, Orthotics, and Supplies Procedure Codes and Coverage Guidelines* manual are included in the NYRx transition. As of April 1, 2023, claims for MMC members for items in these sections are reimbursed through NYRx or DMEPOS FFS providers and billed directly to Medicaid. All prior approval/authorization systems or procedures are in effect as for current FFS members: • **Medicaid Managed Care members:** Covered for tube-fed individuals who cannot chew or swallow food; those with rare inborn

Service	Requirement	Comments
		metabolic disorders requiring specific medical formulas to provide essential nutrients not available through other means; and children who require medical formulas due to mitigating factors in growth and development. • **CHPlus members:** Coverage based on medical necessity for treatment of specific diseases; $2,500 per calendar year for modified solid food products that contain low or modified protein used to treat inherited diseases of amino acid and organic acid metabolism.
Family planning/STD care	Self-referral	• **Medicaid Managed Care members**: May self-refer to an in-network or out-of-network provider. • Covered services include pelvic and breast examinations, lab work, drugs, biological, genetic counseling, and devices and supplies related to family planning (for example, IUD). Family planning drugs and supplies (for example, condoms) are covered by Medicaid NYRx. • Infertility services and treatment are not covered.
Gastroenterology services	No precertification required for network provider for E&M, testing and procedures	Precertification is required for bariatric surgery, including insertion, removal, and/or replacement of adjustable gastric restrictive devices and subcutaneous port components, and all endoscopies. See the *Diagnostic testing* section of this grid.
Gynecology	Self-referral	• Self-referral to a network provider. • No precertification is required for E&M, testing and procedures.
Hearing aids		• Precertification is required for digital hearing aids. • **CHPlus members**: Hearing aids, including batteries and repairs, are covered. • **Medicaid Managed Care members**: Hearing aid and batteries are covered. Due to the NYS Pharmacy Benefit Transition, as of April 1, 2023, hearing aid batteries when provided by DME providers are covered under NYRx.
Hearing screening		• Simple hearing exams require PCP referral only. No notification or precertification is required for coverage of diagnostic and screening tests, hearing aid evaluations, or counseling. • **CHPlus members**: One hearing examination per calendar year is covered. If an auditory deficiency requires additional hearing exams and follow-up exams, these exams will be covered.
Home-delivered meals		• **Medicaid Managed Care members**: This is not a covered benefit. • **CHPlus members**: This is not a covered benefit.
Home healthcare (including behavioral health)	Precertification	• Precertification is required. • Covered services include skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, social work services, and telehealth services when provided by NYSDOH-approved agencies. • **CHPlus members**: Home care services are limited to 40 visits per year for all types of service combined. Private duty nursing is not a covered benefit.

Service	Requirement	Comments
Home modifications		• **Medicaid Managed Care members:** This is not a covered benefit. • **CHPlus members**: This is not a covered benefit.
Hospital admission	Precertification	• Emergency admissions require notification within 24 hours or the next business day. • To be covered, preadmission testing must be performed by an Anthem preferred lab vendor. See the provider referral directory for a complete listing of participating vendors. • Precertification required for same-day/ambulatory surgeries • No coverage for personal comfort and convenience items and services and supplies not directly related to the care of the patient (such as telephone charges, take-home supplies, and similar costs).
Laboratory services (outpatient)	Precertification	• All laboratory services furnished by non-network providers require precertification by Anthem, except for hospital laboratory services in the event of an emergency medical condition. • For offices with limited or no office laboratory facilities, lab tests may be referred to one of the Anthem preferred lab vendors. • See the provider referral directory for a complete listing of participating vendors.
Medical supplies		• Consumable medical supplies and equipment are items other than drugs, prosthetic or orthotic appliances, or DME which have been ordered by a qualified practitioner in the treatment of a specific medical condition and which are: consumable, nonreusable, disposable, or for a specific rather than incidental purpose and generally have no salvageable value. Disposable medical supplies are disposed of after use by a single individual. • **Medicaid Managed Care members**: Supplies do not require precertification and are covered and billable under medical benefits similar to DME. Some medical supplies, such as insulin syringes, test strips, lancets, and spacers, are covered under pharmacy. Visit our website for code-specific information. • Medical supplies used during home care services are covered as part of the home care service rate. A list of these supplies can be found in the *Medicaid Management Information Systems (MMIS) Home Health Services Provider Manual*. • Due to the NYS Pharmacy Benefit Transition, as of April 1, 2023, medical supplies located in *Sections 4.1*, *4.2*, and *4.3* of the *New York State Medicaid DME, Prosthetics, Orthotics, and Supplies Procedure Codes and Coverage Guidelines* manual provided by DME providers are covered under NYRx. • **CHPlus members:** Medical supplies are not covered with the exception of diabetic supplies and medical supplies that are routinely furnished as part of a clinic or office visit which is covered by Anthem. Medical supplies used during home care services are covered as part of the home care service rate. A list of these supplies can be found in the *MMIS Home Health Services Provider Manual*.

Service	Requirement	Comments
Neurology	No precertification required for network provider for E&M and testing	Precertification is required for neurosurgery, spinal fusion, and artificial intervertebral disc surgery. See the *Diagnostic testing* section of this grid.
Observation		Observation services are covered for patients who are seen, evaluated, and admitted to an observational unit. Precertification is not required for participating facilities.
Obstetrical care		• No precertification is required for coverage of obstetrical (OB) services including obstetrical visits, diagnostic tests, and laboratory services when performed by a participating provider. • Notification to Anthem is required at the first prenatal visit. • No precertification is required for coverage of labor and delivery of for circumcision for newborns up to 12 weeks of age. • Notification of delivery is required within 24 hours with newborn information. OB case management programs are available. See the *Diagnostic testing* section of this grid. • One sonogram is covered per pregnancy; additional sonograms are covered with submission of supportive applicable diagnosis codes.
Ophthalmology		Superior Vision: • Provides routine vision care. • Phone Number **800-879-6901** • Medicaid Managed Care, CHPlus, MLTC/MAP, and Essential Plan
Oral maxillofacial	Precertification	See the *Plastic/cosmetic/reconstructive surgery* section of this grid.
Orthodontic care	Precertification	• **Medicaid Managed Care members:** Covered for children up to age 21 who have severe problems with teeth that causes difficulty chewing foods such as severely crooked teeth, cleft palette, or cleft lip. Providers may call LIBERTY at **888-352-7924**. • **CHPlus members:** Not covered
Orthotics and prosthetics/ orthopedic footwear	Precertification	• Orthotic devices are those devices used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body. Prosthetic appliances are those appliances and devices ordered by a qualified practitioner that replace any missing part of the body. • Precertification is required for certain orthotic devices. For code-specific precertification requirement for DME, refer to our website; go to the *Quick Tools* menu and select **Prior Authorization Lookup Tool**. • **Medicaid Managed Care members**: Orthotics and prosthetics are subject to Medicaid coverage and limits. Coverage for orthopedic footwear only for children under 21 years of age that require orthopedic footwear, shoes attached to a lower-limb orthotic brace, or as a component of a comprehensive diabetic treatment plan to treat amputation, ulcerations, pre-ulcerative calluses, peripheral neuropathy with evidence of callus formation, foot deformities, or poor circulation. • **CHPlus members**: Orthotic devices prescribed solely for use during sports are not covered. There is no coverage for cranial prosthesis

Service	Requirement	Comments
		(for example, wigs) and dental prosthesis, except those made necessary due to accidental injury to sound, natural teeth and provided within 12 months of the accident, and except for dental prosthesis needed in treatment of congenital abnormality or as part of reconstructive surgery.
Otolaryngology (ENT) services	No precertification for network provider for E&M, testing and procedures	Precertification required for tonsillectomy and/or adenoidectomy, nasal/sinus surgery, and cochlear implant surgery and services. See the *Diagnostic testing* section of this grid.
Out-of-area/ out-of-network care	Precertification	• Precertification is required with the exception of emergency care (including self-referral). • Out-of-area care is only covered for emergent services; elective services are not covered. • Out-of-network care is only covered in instances of continuity of care for new enrollees, instances where the provider leaves the network, or if an in-network provider is not available to perform the service. • **CHPlus members**: This is not a covered benefit except for emergency services.
Outpatient/ ambulatory procedure/surgery	Precertification	• Precertification requirements are based on the services rendered. Please visit our website for code-specific requirements. • **Medicaid Managed Care members:** Knee arthroscopy when the primary diagnosis is osteoarthritis of the knee (without mechanical derangement of the knee) is not covered.
Pain management	Precertification	• Precertification is required for all services and procedures. • **Medicaid Managed Care members:** Prolotherapy, intradiscal steroid injections, facet joint steroid injections, systemic corticosteroids, and traction (continuous or intermittent) for lower back pain are not covered.
Pharmacy		Beginning April 1, 2023, the pharmacy benefit for Medicaid Managed Care and HARP members transitioned to the NYRx Medicaid Pharmacy Program. Anthem will continue to cover pharmacy benefit for Child Health Plus members. The pharmacy benefit covers medically necessary prescription and over-the-counter (OTC) drugs prescribed by a licensed provider. Exceptions and restrictions exist as the benefit is provided under a closed formulary/Preferred Drug List (PDL). Please refer to the appropriate *CHPlus PDL* and/or the *Medicaid Medication Formulary* for the preferred products within therapeutic categories as well as requirements around generics, prior authorization (PA), step therapy, quantity edits, and the PA process. Note: Be sure to check the back of the member's ID card for applicable pharmacy information. The *CHPlus PDL* and formulary are housed on our provider self-service site.

<table>
<tr><th>Service</th><th>Requirement</th><th>Comments</th></tr>
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Enteral formula is covered for CHPlus members under the DME benefit. See the DME section of this grid.
Growth hormone injections solely for Idiopathic Short Stature (ISS) in children are not covered.
PA is required for all nonformulary drugs and other certain medications.
Many self-injectable medications, self-administered oral specialty medications, and office-administered specialty medications are available through CarelonRx or pharmacies in our specialty network and require PA.
To determine if a medical injectable (in other words, buy and bill) requires precertification, go to the Quick Tools section of our website, and select Prior Authorization Lookup Tool. For a complete list of covered injectables, visit the Precertification and Claims section of our website.
Important phone numbers are below.

<table>
<tr><th>If you need to:</th><th>Call or fax:</th></tr>
<tr><td>Initiate a PA request for:
CHPlus members
Medical injectables covered under the medical benefit for all members</td><td>Anthem Provider Services Prior Authorization:
800-450-8753
Pharmacy PA Requests (for CHPlus):
844-490-4877
For Medicaid and HARP, contact NYRx:
877-309-9493
Physician buy and bill PA requests (all members):
844-493-9206</td></tr>
<tr><td>Schedule delivery for specialty drugs once you receive a PA approval notice for CHPlus members</td><td>CarelonRx phone:
833-255-0646
CarelonRx fax:
833-263-2871</td></tr>
<tr><td>Send a prescription through mail order — CHPlus only</td><td>CarelonRx phone:
833-203-1742
CarelonRx fax:
800-378-0323</td></tr>
</table>
</td></tr>
<tr><td>Physiatry</td><td>Precertification</td><td>Precertification is required for coverage of all services and procedures related to pain management.</td></tr>
<tr><td>Pain management</td><td>Precertification</td><td>Precertification is required for coverage of all services and procedures related to pain management:
Use the Prior Authorization Look Up Tool to determine precertification:
https://providers.anthem.com/ny > Claims > Prior Authorization Lookup Tool.</td></tr>
</table>

Service	Requirement	Comments
Plastic/cosmetic/ reconstructive surgery (including oral maxillofacial services)		• No precertification is required for coverage of E&M codes. • All other services require precertification. Services considered cosmetic in nature are not covered. Services related to previous cosmetic procedures are not covered (for example, scar revision, keloid removal resulting from pierced ears). Reduction mammoplasty requires medical director's review. • No precertification is required for coverage of oral maxillofacial E&M services. • Precertification is required for coverage of trauma to the teeth and oral maxillofacial medical and surgical conditions, including TMJ.
Podiatry		• No precertification for coverage of E&M, testing and procedures when provided by a participating podiatrist. • **Medicaid Managed Care members**: Services provided by a podiatrist for persons under age 21 and adults with diabetes must be covered upon referral of a physician, registered physician assistant, certified nurse practitioner or licensed midwife.
Radiation therapy		• Use the *Prior Authorization Look Up Tool* to determine precertification: **https://providers.anthem.com/ny** > Claims > Prior Authorization Lookup Tool
Radiology services		• Carelon Medical Benefits Management conducts all precertification requests for radiology services. • Use the *Prior Authorization Look Up Tool* to determine precertification: • **https://providers.anthem.com/ny** > Claims > Prior Authorization Lookup Tool • See the *Diagnostic testing* section of this grid.
Rehabilitation therapy (short-term): OT, PT, RT, and ST	Precertification	• Precertification is required for outpatient therapy services. Providers should contact Carelon Medical Benefits Management at **www.providerportal.com** or **call 800-714-0040 (there is no fax option).** Members needing therapy to learn or participate in a school setting should be evaluated for school-based therapy. Other therapy services for rehabilitative care will be covered as medically necessary. • **Medicaid Managed Care members:** Limits do not apply to outpatient visits for physical, occupational, and speech therapy. Visits are based on medical necessity for PT, OT, and ST • **CHPlus members:** 40 visits per calendar year combined with OT (total between PT and OT cannot exceed 40 visits.) Speech therapy has no benefit limit and is on medical necessity. Visits are based on medical necessity. PT, OT, and ST for children diagnosed with autism spectrum disorder are also covered when such treatment is deemed habilitative or nonrestorative. • All therapy services are subject to retrospective utilization review.
Referral		• A referral is required for all specialty visits. The referral should be obtained from the member's PCP. There is no specific Anthem referral form. Referrals can be given on prescription or stationery. • No precertification is required for in-network referral. • All out-of-network referrals require precertification.

Service	Requirement	Comments
Skilled nursing facility	Precertification	Precertification is required for coverage of all services.
Smoking cessation counseling		• No precertification or notification is required. Smoking cessation counseling must be provided by a physician, registered physician's assistant, registered nurse practitioner, or licensed midwife during a medical visit (no group sessions). • All Medicaid Managed Care members are allowed up to eight counseling sessions within a continuous 12-month period. Use diagnosis codes 99406 and 99407.
Specialty referral		• A referral is required for all specialty visits. The referral should be obtained from the member's PCP. There is no specific Anthem referral form. Referrals can be given on prescription or stationery. • There is no precertification required for in-network referral. • All out-of-network referrals require precertification.
Sterilization		• Sterilization services are a covered benefit for members aged 21 and older. • No precertification or notification is required for coverage of sterilization procedures, including tubal ligation and vasectomy. • **A sterilization consent form is required for claims submission.** For hysterectomies, use form *3133*. For sterilizations, use form *3134*. • Reversal of sterilization is not a covered benefit.
Transportation (nonemergent)		• No precertification or notification is required except for planned air transportation (airplane). To arrange transportation, contact Medical Answering Services (see the *Quick Reference Information* section for the correct phone numbers). • **CHPlus members**: This is not a covered benefit.
Urgent care center		No notification or precertification is required for a participating facility.
Vision services — Medicaid Managed Care/CHPlus		• Vision services are administered through Superior Vision. Members may contact Superior Vision at **800-428-8789**. Providers may contact Superior Vision at **800-243-1401**. • **Medicaid Managed Care**: Members are allowed to self-refer to any participating provider of vision services (optometrist or ophthalmologist) for refractive vision services once every two years unless otherwise justified as medically necessary or unless eyeglasses are lost, damaged, or destroyed. Eyeglasses and examinations are limited to once every 24 months unless otherwise justified as medically necessary. Contact lenses are covered once every 24 months only when medically necessary. Members who are diagnosed with diabetes are eligible for an annual dilated eye (retinal) examination. • **CHPlus members**: Vision examinations performed by a physician or optometrist for the purpose of determining the need for corrective lenses and, if needed, to provide a prescription are covered. Vision examinations and eyeglasses are covered every 12-month period. • Members are financially responsible for upgrades of frames and/or lenses that are not medically necessary (for example, personal preference upgrades).

Service	Requirement	Comments
Well-woman exam	Self-referral	Two well-woman exams are covered per calendar year when performed by a PCP or an in-network GYN. Exam includes routine lab work, STD screening, Pap smear, and mammogram (age 35 or older).
Revenue codes		Precertification or notification is required for services billed by facilities with revenue codes for inpatient, OB, home healthcare, hospice, MRI, high-dollar injectables, chemotherapeutic agents, pain management, rehabilitation (physical/occupational/respiratory therapy), and rehabilitation short-term (speech therapy). For a list of the specific revenue codes requiring precertification, please refer to our website.

We're staffed with clinical professionals who coordinate services provided to members and are available 24 hours a day, 7 days a week to accept precertification requests. When we receive your request for medical services via fax, the precertification assistant will verify eligibility and benefits, which will then be forwarded to the nurse reviewer.

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

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

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

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

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

Inpatient Reviews

Inpatient Admission Reviews

All inpatient hospital admissions, including urgent and emergent admissions, will be reviewed within one business day. An Anthem Utilization Review (UR) clinician determines the member's medical status through communication with the hospital's UR department. Appropriateness of stay is documented, and the concurrent review is initiated. Cases may be referred to the medical director, who renders a decision regarding the coverage of hospitalization. Diagnoses meeting specific criteria are referred to the medical director for possible coordination by the care management program.

Inpatient Concurrent Review

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

When one of our UM clinicians reviews the medical record at the hospital, they also attempt to speak with the member and family to discuss any discharge planning needs and verify that the member or

family is aware of the member's PCP's name, address and telephone number. The UM clinician will conduct continued stay reviews daily and review discharge plans unless the patient's condition is unlikely to change within the upcoming 24 hours and discharge planning needs cannot be determined.

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

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

We will authorize covered length of stay one day at a time based on the clinical information that supports the continued stay. Exceptions to the one-day length of stay authorization are made for confinements when the severity of the illness and subsequent course of treatment is likely to be several days or is predetermined by state law. Exceptions are made by the medical director.

If, based upon appropriate criteria and after attempts to speak to the attending physician, the medical director denies coverage for an inpatient stay request, the appropriate notice of determination will be mailed to the hospital, the member's PCP and the member.

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

When long-term care is necessary, we work with you to plan the member's discharge to an appropriate setting for extended services. These services can often be delivered in a nonhospital facility, such as a:

- Hospice facility
- Convalescent facility
- Home health care program (for example, home IV antibiotics)

When you identify medically necessary and appropriate services for the member, we will assist you and the discharge planner in providing a timely and effective transfer to the next appropriate level of care.

Discharge plan authorizations follow Millman (MCG) and other Elevance Health criteria guidelines. Authorizations include, but are not limited to, transportation, home health, DME, pharmacy, follow-up visits to practitioners or outpatient procedures.

Confidentiality of Information

Utilization management, case management, disease management, discharge planning, quality management, and claims payment activities are designed to ensure patient-specific information, particularly protected health information obtained during review. Information is kept confidential in accordance with applicable laws, including *HIPAA*, and is used for the purposes defined above. Information is shared only with entities who have the authority to receive such information and only with those individuals who need access to such information in order to conduct utilization management and related processes.

Emergency Services

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

We do not discourage members from using the 911 emergency system or deny access to emergency services. Emergency services are provided to members without requiring precertification. Emergency services coverage includes services needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

An emergency medical condition is defined as a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and/or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

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

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

If there is concern surrounding the transfer of a patient (for example, whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstable transfer outweigh the risks), the judgment of the attending physician(s) caring for the member at the treating facility prevails and is binding on Anthem. If the emergency department is unable to stabilize and release the member, we will assist in coordination of the inpatient admission regardless of whether the hospital is network or non-network. All transfers from non-network to network facilities are to be conducted only after the member is medically stable and the facility is capable of rendering the required level of care.

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

Urgent Care

We require our members to contact their PCPs in situations where urgent, unscheduled care is necessary. Precertification with us is not required for a member to access a participating urgent care center.

11 QUALITY MANAGEMENT

Quality Management Program Overview

We operate a comprehensive Quality Management program with methods and procedures to control the utilization of services (per *Article 49* of the PHL and *42 CFR Part 456*). The purpose of our Quality Management program is to objectively monitor and systematically evaluate the care and service provided to members. The scope and content of the program reflects the demographic and epidemiological needs of the population served; we'll amend it as needed to address the specific monitoring requirements for the benefits and services we manage and the populations we serve. Members and providers have opportunities to make recommendations for areas of improvement. The Quality Management program goals and outcomes are kept on file in written form. To request a copy, providers and members can call the Quality Management (QM) department at fax-qi@anthem.com.

The initial program development was based on a review of the needs of the population served. Systematic re-evaluation of the needs of the plan's specific population occurs on an annual basis. This includes not only age/gender distribution, but also a review of utilization data, or the information needed to perform utilization reviews (per *42 CFR §§ 456.111* and 456.211) — inpatient, emergent/urgent care, and office visits by type, cost, and volume. This information is used to define areas that are high volume or that are problem prone. Studies are planned across the continuum of care and service, with ongoing proactive evaluation and refinement of the program.

There is a comprehensive committee structure in place with oversight from our governing body. Not only are the traditional Medical Advisory Committee, Credentials Committee and Quality Committee in place, but a Member and Consumer Advisory Committee are also integral components of the Quality Management Program committee structure.

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

Quality of Care

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

Review standards are based on medical community standards, external regulatory and accrediting agencies' requirements, and contractual compliance.

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

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

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

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

Quality Management Committee

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

The Quality Management committee's responsibilities are to:

- Establish strategic direction and monitor and support implementation of the Quality Management program.
- Establish processes and structure that ensure NCQA compliance.
- Review planning, implementation, measurement, and outcomes of clinical/service quality improvement studies.
- Coordinate communication of quality management activities throughout the health plans.
- Review HEDIS® data and action plans for improvement.
- Review and approve the annual quality management program description.
- Review and approve the annual work plans for each service delivery area.
- Provide oversight and review of delegated services.
- Provide oversight and review of subordinate committees.
- Receive and review reports of Utilization Review decisions and take action when appropriate.
- Analyze member and provider satisfaction survey responses.
- Monitor the plan's operational indicators through the plan's senior staff.

Medical Advisory Committee
The Medical Advisory Committee (MAC) has multiple purposes. The MAC assesses levels and quality of care provided to members and recommends, evaluates, and monitors standards of care. The MAC identifies opportunities to improve services and clinical performance by establishing, reviewing, and updating clinical practice guidelines based on review of demographics and epidemiologic information to target high-volume, high-risk, and problem-prone conditions. The MAC oversees the peer review process that provides a systematic approach for the monitoring of quality and the appropriateness of care.

The MAC advises the health plan administration in any aspect of the health plan policy or operation affecting network providers or members. The MAC approves and provides oversight of the peer review process, the Quality Management program, and the Utilization Review program. It oversees and makes recommendations regarding health promotion activities.

The MAC's responsibilities are to:

- Use an ongoing peer review system to monitor practice patterns to identify appropriateness of care and to improve risk prevention activities.
- Approve clinical protocols/guidelines which help ensure the delivery of quality care and appropriate resource utilization.
- Review clinical study design and results.
- Develop action plans/recommendations regarding clinical quality improvement studies
- Oversee member access to care.
- Review and provide feedback regarding new technologies.
- Approve recommendations from subordinate committees.

Quality Assurance Reporting Requirements
Quality Assurance Reporting Requirements (QARR) applies to Child Health Plus, Family Health Plus, Essential Plan, and Medicaid Managed Care.

QARR is a program overseen by the NYSDOH that monitors health plan quality in NYS. The program consists of a series of age-specific and/or health-specific measures designed to examine managed care plan performance in several key areas. QARR data is collected through encounter (claims) data from inpatient or outpatient visits, pharmacy data, laboratory claims or from the member's medical record. The DOH uses QARR data to work with plans and providers to enhance the healthcare outcomes of managed care members through performance feedback, quality improvement programs, technical assistance and highlighting of best practices. All Medicaid health plans in NYS are required to submit QARR data.

Examples of measures reported for QARR include:

- Well-child visits: 15 months, 3 to 6 years, and 12 to 21 years
- Child/adult access to care
- Immunizations completed by age 2
- Lead testing prior to the age of 25 months
- Timeliness and frequency of prenatal care and timeliness of postpartum care
- Comprehensive diabetes care
- Screening of adolescents for alcohol/substance use and tobacco use
- Breast cancer screening
- Cervical cancer screening

- Appropriate treatment of asthma
- HIV/AIDS Comprehensive Care

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

Quality Incentives
We offer quality incentives to providers for completing services that meet certain QARR measures, as well as to those providers whose preventive scores are significantly above average (please refer to your individual contract for information on monetary incentives for QARR compliance).

Provider Profiling

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

The principal features of the methodology are:

- Clearly defined goals and objectives for the profiling activity have been developed, including the communication of a profiling summary to providers and the provision of provider/office manager education, based on findings and corrective action plans with timetables and measurable benchmarks of success, as indicated.
- Descriptions and rationale for each measure have been developed, and supporting clinical documentation included, when appropriate.
- The measures selected for the profile meet criteria for valid and reliable measurement and when analyzed as a whole, will be used as a tool to target opportunities for improvement. Additionally, a summary of these results will be shared with the involved physicians to promote continuous quality improvement activities.
- Profiles examine a broad range of practice measures and have some adjustments for risk, and similar cohorts are analyzed across practices to fairly compare each provider.
- Profiles include data from multiple sources, including claims, QARR, medical record review data, utilization management and pharmacy data, member satisfaction surveys, enrollment and PCP assignment data, member complaints and provider-supplied information, such as office hours, walk-in policies, etc.

Measure Selection Criteria
The measures selected for the physician quality profile met the following criteria:

- The definition of the measure has been consistent over one year, meaning that the measurement methodology has not changed appreciably.
- Data has been reported in the measurement area for a minimum of one year.
- The measure is readily understood, and its validity accepted.
- The data for the measure are available and meet accepted standards for completeness.
- The size of the population for selecting a measure is adequate. A panel size limit (completed only for panels of 100 or more) has been selected. In relation to QARR scores when reviewed

by an individual provider, the population will often be too small to provide a statistically significant result, but will nonetheless be reviewed as one measure of the provision of services.

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

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

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

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

Utilization:

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

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

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

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

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

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

Public Health Issues

We work with the NYC and NYS Departments of Health to identify, track and, when possible, address any public health issues that may arise in our member population. Some areas of focus are communicable disease reporting, lead testing and reporting, accessing and reporting to the City Immunization Registry (CIR), and child abuse and domestic violence identification and follow-up.

Domestic Violence
You're expected to screen for cases of domestic violence as part of routine assessments and should provide members with appropriate referrals when indicated. Questions regarding domestic violence should be referred to the Associate Vice President of Behavioral Health or the Domestic Violence Coordinator at **800-450-8753**. In addition, you may contact the NYS Domestic Violence Hotline at **800-942-6906**.

HIV Testing
Effective November 2016, the amendments to New York State Law under *Chapter 502* required that HIV testing is offered to all individuals 13 years of age and older. Please note the following additional guidelines:

- At a minimum, the individual must be advised that an HIV-related test is going to be performed.
- No test can be performed if the individual objects.
- Any objection by the individual must be noted in the individual's medical record.

An HIV test should be part of routine medical care. For the *Authorization for Release of Health Information* and *Confidential HIV Related Information* forms, go to **health.ny.gov/diseases/aids/providers/forms/informedconsent.htm**. Additional information regarding HIV testing laws can be found at **health.ny.gov/diseases/aids/testing/law/faqs.htm**.

12 CREDENTIALING PROGRAM SUMMARY

Anthem's discretion

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

Credentialing Scope

Credentialing requirements apply to the following:

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

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

1. Individual or group practices;
2. Facilities;
3. Rental networks:
    - That are part of Anthem's primary Network and include Anthem Members who reside in the rental network area.
    - That are specifically for out-of-area care and Members may see only those practitioners or are given an incentive to see rental network practitioners; and
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 (e.g., physical therapists, speech therapists, and occupational therapists)
- Genetic counselors
- Audiologists

- Acupuncturists (non-MD/DO)
- Nurse practitioners
- Certified nurse midwives
- Physician assistants (as required locally)
- Registered Dietitians

The following behavioral health practitioners are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services:

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

Anthem credentials the following Health Delivery Organizations (HDOs):

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

The following HDOs are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process 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 (e.g., nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair's discretion. At least two of the physician committee members must be credentialed for each line of business (e.g., Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant's participation or terminate a practitioner from participation in one or more Networks or Plan programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are network practitioners.

During the credentialing process, all information that is obtained is confidential and not subject to review by third parties except to the extent permitted by law. Access to information will be restricted to

those individuals who are deemed necessary to attain the objectives of the Credentialing Program. Specifically, information supplied by the practitioner or HDO in the application, as well as other non-publicly available information will be treated as confidential. Confidential written records regarding deficiencies found, the actions taken, and the recommended follow-up will be kept in a secure fashion. Security mechanisms include secured office facilities and locked filing cabinets, a protected computer infrastructure with password controls and systematic monitoring, and staff ethics and compliance training programs. The procedures and minutes of the CC will be open to review by state and federal regulatory agencies and accrediting bodies to the extent permitted by law.

Practitioners and HDOs are notified of their right to review information submitted to support their credentialing applications. 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 utilized. To learn more about CAQH, visit their web site at www.CAQH.org.

Anthem will verify those elements related to an applicants' legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the 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

A. Health care practitioners:

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

A. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP;
B. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he or she provides services to Members;

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

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

A. For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine ("ABPM"), or American Board of Oral and Maxillofacial Surgery (ABOMS) in the clinical discipline for which they are applying.
B. If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
C. If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.
D. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.
    1. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
        i. Previous board certification (as defined by one) of the following: ABMS, AOA, RCPSC, CFPC, ABFAS, ABPM, or ABOMS) in the clinical specialty or subspecialty for which they are applying which has now expired and a minimum of 10 consecutive years of clinical practice;
        ii. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty; or
        iii. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty and a faculty appointment of assistant professor or higher at an academic medical center and teaching facility in Anthem's network and the applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.
    2. Practitioners meeting one of these three alternative criteria (i., ii., iii.) will be viewed as meeting all Anthem education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Anthem review and approval. Reports submitted by delegates to Anthem must contain sufficient documentation to support the above alternatives, as determined by Anthem.

E. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (DNV NIAHO), Center for Improvement in Healthcare Quality (CIHQ), 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.

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

Criteria for Selecting Practitioners

New Applicants (Credentialing):

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

    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 all the following criteria are met:

a. It can be verified that the applicant's application is pending; and
b. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
c. The applicant agrees to notify Anthem upon receipt of the required DEA registration; and
d. Anthem will verify the appropriate DEA/CDS registration via standard sources; and
e. The applicant agrees that failure to provide the appropriate DEA registration within a 90-day timeframe will result in termination from the network.

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

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

11. 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.
12. No history of or current use of illegal drugs or history of or current substance use disorder.
13. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
14. 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.
15. 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.
16. A minimum of the past 10 years of malpractice claims history is reviewed.
17. 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;
18. No involuntary terminations from an HMO or PPO.
19. No "yes" answers to attestation/disclosure questions on the application form with the exception

of the following:

a. Investment or business interest in ancillary services, equipment or supplies;
b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
c. Voluntary surrender of state license related to relocation or nonuse of said license;
d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
e. Non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window.
g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

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

Participation Criteria and Exceptions for Non-Physician Credentialing.

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

1. Licensed Clinical Social Workers (LCSW) or other master level social work license type:
   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 (e.g., MD/DO, PsyD, SW, RNCS, ARNP, and MFT, OR LPC) at the highest level of independent practice in the state where the practice is to occur OR must be licensed or certified as a pastoral counselor in the state where the practice is to occur.
   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.
4. 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.

5. Clinical Neuropsychologist:
   a. Must meet all the criteria for a clinical psychologist listed in Section 4 above and be Board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN);
   b. A practitioner credentialed by the National Register of Health Service Providers (National Register) in psychology with an area of expertise in neuropsychology may be considered; and
   c. Clinical neuropsychologists who are not board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
      i. Transcript of applicable pre-doctoral training;

ii. Documentation of applicable formal one-year post-doctoral training (participation in CEU training alone would not be considered adequate);
iii. Letters from supervisors in clinical neuropsychology (including number of hours per week); or
iv. Minimum of five years' experience practicing neuropsychology at least ten hours per week.

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

7. Process, requirements and Verification – Nurse Practitioners:
   a. The nurse practitioner (NP) applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
   b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur 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 his/her certification has expired, the application will be submitted for individual review.

f. If the NP has hospital privileges, he or she must have hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee. Information regarding 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.

8. Process, Requirements and Verifications – Certified Nurse Midwives:

a. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training and board certification.
b. The required educational/training will be at a minimum that required for licensure as a registered nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur 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:
    iv. The National Certification Corporation for Ob/Gyn and neonatal nursing; or

v. 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.

j. 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.

k. 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.

l. 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.

m. 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.

9. Process, Requirements and Verifications – Physician's Assistants (PA):
   a. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
   b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
   c. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
   d. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Anthem procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.

e. All PA applicants will be certified by the National Commission on Certification of Physician's Assistants. This certification must be active 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. PA's will be clearly identified:
    iv. On the credentialing file;
    v. At presentation to the CC; and
    vi. 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.

B. HDO Eligibility Criteria

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

would adversely affect quality or care or patient safety. HDOs are re-credentialed at least every three years to assess the HDO's continued compliance with Anthem standards.

A. General Criteria for HDOs:
   1. 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.
   2. Valid and current Medicare certification.
   3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the FEHBP. Note: If, once an HDO participates in 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.
   4. Liability insurance acceptable to Anthem.
   5. If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if Anthem's quality and certification criteria standards have been met.

B. Additional Participation Criteria for HDO by Provider Type:

HDO TYPE AND ANTHEM APPROVED ACCREDITING AGENT(S)

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

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	DNV NIAHO, ACHC, TJC, TCT
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, TJC, ACHC
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF

Intensive Outpatient – Mental Health and/or Substance Use Disorder	ACHC, CARF, COA, DNV NIAHO, TJC
Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinics	CARF, CHAP, COA, ACHC, TJC
Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Use Disorder	CARF, DNV NIAHO, TJC
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Use Disorder	CARF, COA, DNV NIAHO, ACHC, TJC

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

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

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

13 PROVIDER COMPLAINT PROCEDURES

We have a formal complaint and appeal process for the handling of disputes pertaining to administrative issues and nonpayment related matters. For payment disputes, see the Provider Payment Disputes section of this manual. You may access this process by filing a written complaint. Your complaints will be resolved fairly, consistent with our policies and covered benefits.

You aren't penalized for filing complaints. Any supporting documentation should accompany the complaint.

File grievances in writing to:

Anthem
Grievance and Appeals
PENN 1, 35th Floor
New York NY 10119
Email: **nyproviderinquiries@anthem.com**

We'll send you an acknowledgement letter within 10 business days of receipt. At no time will we cease coverage of care pending a grievance investigation.

14 CLAIM SUBMISSION AND ADJUDICATION PROCEDURES

Electronic Claims Submission

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

Use Availity for the following EDI transactions:

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

Availity's EDI submission options:

- EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software). To register for direct EDI transmissions, visit **https://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)**.

Availity EDI Payer IDs:

- For Professional claims: 00803
- For Institutional claims: 00303

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

Electronic Remittance Advice (ERA)
The 835 eliminates the need for paper remittance reconciliation.
Use Availity to register and manage ERA account changes with these three easy steps:

- Log in to **https://Availity.com**
- Select **My Providers**
- Select **Enrollment Center** and select **Transaction Enrollment**

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

Electronic Funds Transfer (EFT)

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

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

EDI Submission for Corrected Claims

For corrected electronic claims, the following frequency code:

- 7 – Replacement of Prior Claim

EDI segments required:

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

Please work with your vendor on how to submit corrected claims.

Paper Claims Submission

You also have the option of submitting paper claims. We use Optical Character Reading (OCR) technology as part of our front-end claims processing procedures. The benefits include:

- Faster turnaround times and adjudication
- Claims status availability within five days of receipt
- Immediate image retrieval by our staff for claims information, allowing more timely and accurate response to your inquiries

To use OCR technology, claims must be submitted on original red claim forms (not black and white or photocopied forms), laser printed or typed (not handwritten), and in a large, dark font. You must submit a properly completed *UB-04* or *CMS-1500* (08-05) within 90 days from the date of service.

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

- Patient's ID number
- Patient's name
- Patient's date of birth
- ICD diagnosis codes/revenue codes
- Date of service
- Place of service
- Description of services rendered
- Itemized charges
- Days or units
- Provider tax ID number
- Provider name according to contract
- Anthem provider number
- NPI of billing provider when applicable
- CLIA Identification number when applicable (CMS-1500 only)
- State Medicaid ID number

- COB/other insurance information
- Authorization/precertification number
- Name of referring physician
- NPI of referring physician when applicable
- Any other state required data

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

Paper claims must be submitted within 90 days of the date of service and submitted to the following address:

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

International Classification of Diseases, 10th Revision (ICD-10) Description

As of **October 1, 2015**, ICD-10 became the code set for medical diagnoses and inpatient hospital procedures in compliance with HIPAA requirements, and in accordance with the rule issued by the U.S. Department of Health and Human Services (HHS).

ICD-10 is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaces the International Classification of Diseases, 9th Revision (ICD-9) which was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes. In the United States, the codes are the foundation for documenting the diagnosis and associated services provided across healthcare settings.

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

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

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

Encounter Data

We maintain a system to collect member encounter data. Due to reporting needs and requirements, network providers who are reimbursed by capitation must send us encounter data for each member encounter. Encounter data can be submitted through EDI submission methods or on a *CMS-1500* (08-05) claim form unless we approve other arrangements. Data will be submitted in a timely manner, but no later than 90 days from the date of service.

The encounter data will include the following:

- Member's ID number
- Member's name (first and last name)

- Member's address
- Member's date of birth
- Provider's name according to contract
- Anthem provider number
- Coordination of benefit information
- Date of encounter
- Diagnosis code
- Types of services provided (using current procedure codes and modifiers if applicable)
- Provider's tax ID number and state Medicaid ID number

Encounter data should be submitted to the following address:

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

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

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

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

Claims Adjudication

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

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

We reserve rights to use code-editing software to determine which services are considered part of, incidental to, or inclusive of the primary procedure.

For claims payment to be considered, adhere to the following time limits:

- Submit claims within 90 days from the date the service is rendered or for inpatient claims filed by a hospital within 90 days from the date of discharge.
- In the case of other insurance, submit the claim within 90 days of receiving a response from the third-party payer.

- Claims for members whose eligibility has not been added to the state's eligibility system must be received within 90 days from the date the eligibility is added and we're notified of the eligibility/enrollment.
- Claims submitted after the 90-day filing deadline will be denied.

After filing a claim with us, review the weekly *Explanation of Payment* (*EOP*). If the claim does not appear on an *EOP* within 30 business days as adjudicated or you have no other written indication that the claim has been received, check the status of your claim on our website or by calling Provider Services at **800-450-8753**. If the claim is not on file with us, resubmit your claim within 90 days from the date of service. If filing electronically, check the confirmation reports that you receive from your EDI or practice management vendor for acceptance of the claim.

Clean Claims Payment

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

- Is submitted timely.
- Is accurate.
- Is submitted on a *HIPAA*-compliant standard claim form (*CMS-1500* or *CMS-1450*), or successor forms thereto, or the electronic equivalent of such claim form.
- Requires no further information, adjustment or alteration by provider or by a third party in order for us to process and pay it.

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

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

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

In accordance with state insurance requirements, except in a case where our obligation to pay is not reasonably clear or when there is a reasonable basis that the claim was submitted fraudulently, we'll pay the electronic claim within 30 days or paper claims within 45 days of the date of receipt. In a case where our obligation to pay a claim is not reasonably clear, we'll pay any undisputed portion of the claim and notify you in writing within the appropriate time frame above that we:

- Are not obligated to pay the claim, stating the specific reasons why we are not liable.
- Need additional information to determine liability to pay the claim or make the payment.

Claims Status

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

Reimbursement Policies

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

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedural Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes which indicate the services and/or procedures performed. Claims for physician administered drugs billed as a medical claim require inclusion of the national drug code (NDC). The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

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

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

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

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

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

Medical Coding
The Medical Coding Department ensures that correct coding guidelines have been applied consistently through Blue Cross NY.

- Those guidelines include but are not limited to:
- Correct modifier use.
- Effective date of transaction code sets (CPT, HCPCS, ICD-10 diagnosis/procedures, revenue codes, etc.)

- Code editing rules, appropriately applied and within regulatory requirements.
- Analysis of codes, code definitions and appropriate use.

Reimbursement by code definition
Anthem allows reimbursement for covered services based on their procedure code definition, or descriptor, as opposed to their appearance under a particular CPT category section, unless otherwise noted by state or provider contracts, or state, federal or CMS requirements. There are eight CPT sections:

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

Documentation Standards for an Episode of Care
Anthem requires that upon request for clinical documentation to support claims payment for services, the information provided should:

- Identify the member.
- Be legible.
- Reflect all aspects of care.

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

- Patient identifying information
- Consent forms
- Health history, including applicable drug allergies
- Physical examinations
- Diagnoses and treatment plans for individual episodes of care
- Physician orders
- Face-to-face evaluations, when applicable
- Progress notes
- Referrals, when applicable
- Consultation reports, when applicable
- Laboratory reports, when applicable
- Imaging reports (including X-ray), when applicable
- Surgical reports, when applicable
- Admission and discharge dates and instructions, when applicable
- Preventive services provided or offered, appropriate to member's age and health status
- Evidence of coordination of care between primary and specialty physicians, when applicable

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

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

- Legible to someone other than the writer
- Information identifying the member must be included on each page in the medical record
- Each entry in the medical record must be dated and include author identification, which may be a handwritten signature, unique electronic identifier, or initials
- Other documentation not directly related to the member
- Other documentation not directly related to the member, but relevant to support clinical practice, may be used to support documentation regarding episodes of care, including:
    - Policies, procedures, and protocols
    - Critical incident/occupational health and safety reports
    - Statistical and research data
    - Clinical assessments
    - Published reports/data

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

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

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

Provider Reimbursement

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

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

Some of the benefits providers may experience include:

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

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

PCP Reimbursement
We reimburse PCPs according to their contractual arrangement.

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

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

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

Dual Providers
We reimburse our dual providers based on the taxonomy codes billed on each claim. The Healthcare Provider Taxonomy code set allows providers to identify their specialty categories. For capitated providers, claims billed with taxonomy codes appropriate for a PCP will finalize under capitation. Claims billed with any other taxonomy codes will be reimbursed at FFS specialty rates according to providers' contractual arrangements.

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

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

If a provider identifies an overpayment and submits a refund, a completed *Refund Notification Form* specifying the reason for the return must be included. This form can be found on the provider website at **https://providers.anthem.com/ny** and in the current provider manual on page 192The submission of the *Refund Notification Form* will allow Cost Containment to process and reconcile the overpayment in a timely manner. For questions regarding the refund notification procedure, please call Provider Services at **800-450-8753** and select the appropriate prompt.

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

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

Cost Containment Overpayment Disputes

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

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

The mailing address and fax number are:
Cost Containment - Disputes
PO Box 62427
Virginia Beach, VA. 23466-2437
Fax - 866-920-1874

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

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

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

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

The provision entitled *Reporting and Returning Overpayments – Deadline for Reporting and Returning Overpayments*, codified at *42 U.S.C.A. § 1320a-7k*, clarifies the uncertainty left by the *2009 Fraud Enforcement and Recovery Act*.

This provision of the HealthCare Reform Act applies to providers of services, suppliers, Medicaid managed care organizations, Medicare Advantage organizations, and Medicare Prescription Drug Program sponsors. It does not apply to beneficiaries.

Outlier Reimbursement – Audit and Review Process

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

related to the review may be submitted according to the instructions in the Claims Payment Disputes section of this manual.

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

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

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

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

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

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

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

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

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

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

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

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

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

Operating Room Time and Procedure Charges

The operating room ("OR") charge will be based on a time or procedural basis. When time is the basis for the charge, it should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes. The Operating Room is defined as surgical suites, major and minor, treatment rooms, endoscopy labs, cardiac cath labs, Hybrid Rooms, X-ray, pulmonary and cardiology procedural rooms. The operating room charge will reflect the cost of:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Video or Digital Equipment used in Operating Room or Procedure Room

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

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

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

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0990 – 0999	Personal Care Items Courtesy/Hospitality Room Patient Convenience Items (0990) Cafeteria, Guest Tray (0991) Private Linen Service (0992) Telephone, Telegraph (0993) TV, Radio (0994) Non-patient Room Rentals (0995) Beauty Shop, Barber (0998) Other Patient Convenience Items (0999)
0220	Special Charges
0369	Preoperative Care or Holding Room Charges
0760 – 0769	Special Procedure Room Charge
0111 – 0119	Private Room* (subject to Member's Benefit)
0221	Admission Charge
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) Stand-by Charges
0220, 0949	Stat Charges
0270 – 0279, 0360	Video Equipment Used in Operating Room
0270, 0271, 0272	Supplies and Equipment Blood Pressure cuffs/Stethoscopes Thermometers, Temperature Probes, etc.

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	Pacing Cables/Wires/Probes Pressure/Pump Transducers Transducer Kits/Packs SCD Sleeves/Compression Sleeves/Ted Hose Oximeter Sensors/Probes/Covers Electrodes, Electrode Cables/Wires Oral swabs/toothettes; Wipes (baby, cleansing, etc.) Bedpans/Urinals Bed Scales/Alarms Specialty Beds Foley/Straight Catheters, Urometers/Leg Bags/Tubing Specimen traps/containers/kits Tourniquets Syringes/Needles/Lancets/Butterflies Isolation carts/supplies Dressing Change Trays/Packs/Kits Dressings/Gauze/Sponges Kerlix/Tegaderm/OpSite/Telfa Skin cleansers/preps Cotton Balls; Band-Aids, Tape, Q-Tips Diapers/Chucks/Pads/Briefs Irrigation Solutions ID/Allergy bracelets Foley stat lock Gloves/Gowns/Drapes/Covers/Blankets Ice Packs/Heating Pads/Water Bottles Kits/Packs (Gowns, Towels and Drapes) Basins/basin sets Positioning Aides/Wedges/Pillows Suction Canisters/Tubing/Tips/Catheters/Liners Enteral/Parenteral Feeding Supplies (tubing/bags/sets, etc.) Preps/prep trays Masks (including CPAP and Nasal Cannulas/Prongs) Bonnets/Hats/Hoods Smoke Evacuator Tubing Restraints/Posey Belts OR Equipment (saws, skin staplers, staples & staple removers, sutures, scalpels, blades etc.)

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets, transducers, fluid warmers, heparin and saline flushes, etc.)
0220 – 0222, 0229, 0250	Pharmacy Administrative Fee (including mixing meds) Portable Fee (cannot charge portable fee unless equipment is brought in from another Facility) Patient transport fees
0223	Utilization Review Service Charges
0263	IV Infusion for therapy, prophylaxis (96365, 96366) IV Infusion additional for therapy IV Infusion concurrent for therapy (96368) IV Injection (96374, 96379)
0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310	Nursing Procedures
0230	Incremental Nursing – General
0231	Nursing Charge – Nursery
0232	Nursing Charge – Obstetrics (OB)
0233	Nursing Charge – Intensive Care Unit (ICU)
0234	Nursing Charge – Cardiac Care Unit (CCU)
0235	Nursing Charge – Hospice
0239	Nursing Charge – Emergency Room (ER) or Post Anesthesia Care Unit (PACU) or Operating Room (OR)
0250 – 0259, 0636	Pharmacy (non-formulary drugs, compounding fees, nonspecific descriptions) Medication prep Nonspecific descriptions

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

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

Claim

Payment Disputes

Provider Claim Payment Dispute Process
If you disagree with the outcome of a claim, you may begin the Anthem provider payment dispute process. The simplest way to define a claim payment dispute is when the claim is finalized, but you disagree with the outcome.

Please be aware there are three common, claim-related issues that are not considered claim payment disputes. To avoid confusion with claim payment disputes, we've defined them briefly here:

- Claim inquiry: a question about a claim but not a request to change a claim payment
- Claims correspondence: when Anthem requests further information to finalize a claim; typically includes medical records, itemized bills or information about other insurance a member may have
- Medical necessity appeals: a pre-service appeal for a denied service; for these, a claim has not yet been submitted

For more information on each of these, please refer to the appropriate section in this provider manual.

The Anthem provider payment dispute process consists of two internal steps and a third external step. You will **not** be penalized for filing a claim payment dispute, and no action is required by the member:

1. **Claim payment reconsideration:** This is the first step in the provider payment dispute process. The reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.
2. **Claim payment appeal:** This is the second step in the provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal.

A claim payment dispute may be submitted for multiple reason(s), including:

- Contractual payment issues.
- Disagreements over reduced or zero-paid claims.
- Post-service authorization issues.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Retro-eligibility issues.
- Experimental/investigational procedure issues.
- Claim data issues.
- Timely filing issues.*

* We will consider reimbursement of a claim that has been denied due to failure to meet timely filing if you can: 1) provide documentation the claim was submitted within the timely filing requirements or 2) demonstrate good cause exists.

Claim Payment Reconsideration
The first step in the Anthem claim payment dispute process is called the reconsideration. It is your initial request to investigate the outcome of a finalized claim. Please note, we cannot process a reconsideration without a finalized claim on file.

We accept reconsideration requests in writing, verbally and through our secure provider website within 45 calendar days from the date on the *EOP* (see below for further details on how to submit). Reconsiderations filed more than 45 calendar days from the *EOP* will be considered untimely and denied unless good cause can be established.

When submitting reconsiderations, please include as much information as you can to help us understand why you think the claim was not paid as you would expect. If a reconsideration requires clinical expertise, the appropriate clinical Anthem professionals will review it.

Anthem will make every effort to resolve the claims payment reconsideration within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

We will send you our decision in a determination letter, which will include:

- A statement of the provider's reconsideration request.
- A statement of what action Anthem intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes or provider manual references.
- An explanation of the provider’s right to request a claim payment appeal within 30 calendar days of the date of the reconsideration determination letter.
- An address to submit the claim payment appeal.
- A statement that the completion of the Anthem claim payment appeal process is a necessary requirement before requesting a state fair hearing.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

Claim Payment Appeal

If you are dissatisfied with the outcome of a reconsideration determination you may submit a claim payment appeal. Please note, we cannot process a claim payment appeal without a reconsideration on file.

We accept claim payment appeals through our provider website or in writing within 30 calendar days of the date on the reconsideration determination letter.

Claim payment appeals received more than 30 calendar days after the *EOP* or the claims reconsideration determination letter will be considered untimely and upheld unless good cause can be established.

When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the reconsideration determination was in error. If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate clinical Anthem professionals.

Anthem Blue will make every effort to resolve the claim payment appeal within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

We will send you our decision in a determination letter, which will include:

- A statement of the provider's claim payment appeal request.
- A statement of what action Anthem intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes or provider manual references.
- A statement about how to submit a state fair hearing.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

How to Submit a Claim Payment Dispute

We have several options to file a claim payment dispute:

- Verbally (for reconsiderations only): Call Provider Services.
- Online (for reconsiderations and claim payment appeals): Use the secure Availity Essentials Appeals application at **https://Availity.com**. Through Availity Essentials, you can upload supporting documentation and will receive immediate acknowledgement of your submission.
- Written (claim payment appeals only): Mail all required documentation (see below for more details) to:

Anthem
Payment Dispute Unit
P.O. Box 61599
Virginia Beach, VA 23466-1599

Submit written claim payment appeals on the form *Claim Payment Appeal Form*, located at: **https://providers.anthem.com/ny** >Resources > Forms > Claims.

Required Documentation for Claims Payment Disputes

Anthem requires the following information when submitting a claim payment dispute (reconsideration or claim payment appeal):

- Your name, address, phone number, email, and either your NPI or TIN
- The member's name and their Anthem
- Medicaid ID number
- A listing of disputed claims, which should include the Anthem claim number and the date(s) of service(s)
- All supporting statements and documentation

Claim Inquiries

A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but the outcome of the claim inquiry may result in the initiation of the claim payment dispute. In other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

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

Claim Correspondence

Claim correspondence is different from a payment dispute. Correspondence is when Anthem requires more information to finalize a claim. Typically, Anthem makes the request for this information through the *EOP*. The claim or part of the claim may, in fact, be denied, but it is only because more information is required to process the claim. Once the information is received, Anthem will use it to finalize the claim.

The following table provides examples of the most common correspondence issues along with guidance on the most efficient ways to resolve them.

Type of Issue	What Do I Need to Do?
EDI Rejected Claim(s)	Contact Availity Client Services with any questions at **800-AVAILITY (800-282-4548)** when your claim was submitted electronically but was never paid or was rejected. We're available to assist you with setup questions and help resolve submission issues or electronic claims rejections.
EOP Requests for Supporting Documentation (Sterilization/ Hysterectomy/Abortion Consent Forms, Itemized Bills and Invoices)	Submit a copy of your *EOP* and the supporting documentation to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
EOP Requests for Medical Records	Submit a copy of your *EOP* and the medical records to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
Need to Submit a Corrected Claim due to Errors or Changes on Original Submission	Submit your corrected claim to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599 Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received timely, a corrected claim must be received within 365 days of the date of service. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to Anthem to adjust the other health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI *EOB*.
Submission of Coordination of Benefits (COB)/Third-Party Liability (TPL) Information	Submit a copy of your *EOP* and the COB/TPL information to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
Emergency Room Payment Review	Submit a copy of your *EOP* and the medical records to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599

Medical Necessity Appeals

Medical necessity appeals refer to a situation in which an authorization for a service was denied prior to the service. Medical necessity appeals/prior authorization appeals are different than claim payment disputes and should be submitted in accordance with the medical necessity appeal process.

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

We and our providers agree the Medicaid program will be the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicaid members. When we obtain complete information regarding the responsible carrier prior to paying for a medical service, we will avoid payment by either rejecting your claim and redirecting you to bill the appropriate insurance carrier or, if we do not become aware of the resource until sometime after payment for the service was rendered, by pursuing post-payment recovery of the expenditure. You must not seek recovery in excess of the Medicaid payable amount.

We will avoid payment of trauma-related claims where third-party resources are identified prior to payment. Otherwise, we will investigate prospective and potential subrogation cases on behalf of the state. Paid claims are reviewed and researched post-payment to verify subrogation cases. This information is reported to the state on a regular basis for management of recoveries related to the healthcare expenses in these cases.

We require members to cooperate in the identification of any and all other potential sources of payment for services. In no instance will a member be held responsible for disputes over these recoveries.

Any questions or inquiries regarding paid, denied or pended claims should be directed to Provider Services at **800-450-8753**.

Billing Members

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

If you choose to provide services we do not cover:

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

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

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

- Failure to timely submit a claim, including claims we don't receive
- Failure to submit a claim to us for initial processing within the 90-day filing deadline
- Failure to submit a corrected claim within the 90-day filing resubmission period
- Failure to appeal a claim within the 30-day administrative appeal period
- Failure to appeal a UR determination within 30 business days of notification of coverage denial

- Submission of an unsigned or otherwise incomplete claim
- Errors made in claims preparation, claims submission or the appeal process

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

- The member requests the specific service or item
- You obtain and keep a written acknowledgement statement signed by you and the member stating:

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

Signature: _____
Date: _____

15 PROVIDER DIRECTORY

Updating Provider Demographic Data

Providers and Facilities must have business processes in place to ensure the timely provision of provider directory information to Anthem. A Provider or Facility must submit such provider directory information to Anthem, at a minimum, when a Provider or Facility begins or terminates a network agreement with Anthem; when there are material changes to the content of the provider directory information of the Provider/Facility; and at any other time, including upon the Anthem's request, as the Provider/Facility determines to be appropriate.

Types of demographic data updates can include, but are not limited to:

- Accepting New Patients
- Address – Additions, Terminations, Updates (including physical and billing locations)
- Areas of Expertise (Behavioral Health Only)
- Email Address
- Handicapped Accessibility
- Hospital Affiliation and Admitting Privileges, including facilities certified or authorized by OMH or OASAS
- Languages Spoken
- License Number
- Board Certifications
- Restrictions regarding the availability of provider's services
- Name change (Provider/Organization or Practice)
- National Provider Identifier (NPI)
- Network Participation
- Office Hours/Days of Operation
- Patient Age/Gender Preference
- Phone/Fax Number
- Provider Leaving Group, Retiring, or Joining another Practice
- Specialty
- Tax Identification Number (TIN) (must be accompanied by a W-9 to be valid)
- Termination of Provider Participation Agreement*
- Web Address

* For notices of termination from an Anthem network, Providers and Facilities should refer to the termination clause in the *Agreement* for specific notification requirements. Allow the number of days' notice of termination from Anthem's network as required by the *Agreement* (for example, 90 days, 120 days, etc.).

APPENDIX A — FORMS

The rest of this page is left intentionally blank.

Specialist as PCP Request Form

Date: _____

Member's name: _____

Member's ID #: _____

PCP's name (if applicable): _____

Specialist/specialty: _____

Member's diagnosis: _____

Describe the medical justification for selecting a specialist as PCP for this member.

_____

_____

_____

_____

_____

The signatures below indicate agreement by the specialist, Anthem and the member for whom the specialist will function as this member's PCP, which includes providing member access 24 hours a day, 7 days a week.

Specialist's signature: _____ Date: _____

Medical director's signature: _____ Date: _____

Member's signature: _____ Date: _____

Medical Record Review Checklist

Provider Name: _____ Date of Review: _____

Specialty: _____ Reviewer: _____

Check One: Audit ___ Credentialing Visit ___ Recredentialing Visit ____

Member Name: **DOB:** **Member #:**												
CRITERIA (Critical indicators are in bold type)	**Y**	**N**	**NA**	**Y**	**N**	**NA**	**Y**	**N**	**NA**	**Y**	**N**	**NA**
1. Patient identification on each page												
2. Biographical/personal data documented												
3. Medical record entries are legible												
4. All entries dated and signed by provider												
5. Medication log												
6. Immunization log up-to-date												
7. Immunization log complete (route, dose, lot number, expiration date)												
8. Immunization log signed by appropriate provider												
9. Allergies and adverse reactions flagged												
10. Completed problem list												
11. Past medical history												
12. Follow-up on past visit problems												
13. Mental health screening												
14. Psychosocial assessment												
15. ETOH/substance/smoking screen-counseling												
16. HIV education, counseling, and screening												
17. Domestic violence/child abuse screening												
18. Pertinent history and physical exam												
19. Working diagnosis consistent with findings												
20. Tx Plan appropriate and consistent with Dx												
21. Return date and follow-up plan on encounter with time												
22. Labs and other studies, as appropriate												
23. Labs and other studies, reviewed and initialed												
24. Appropriate use of specialist/consultants												
25. Continuity and coordination of care with specialist												
26. Consultative reports, reviewed and initialed												
27. Preventive services rendered appropriately												
28. Age appropriate education provided												
29. Appropriate reporting of communicable disease												

Authorization for Release of Health Information and Confidential HIV Related Information Forms

Visit the New York State Department of Health website at **health.ny.gov/diseases/aids/providers/forms/informedconsent.htm** to access the *Authorization for Release of Health Information* and *Confidential HIV Related Information* forms.

Hysterectomy and Sterilization Forms

Visit the U.S. Department of Health and Human Services website located at **hhs.gov/forms** to access the Hysterectomy and Sterilization forms.

Practitioner Clinical Medical Record Review

ANTHEM PRACTITIONER CLINICAL MEDICAL RECORD REVIEW

Physician Name: _____
First Last

Office Address: _____

Physician Specialty: _____ Date: _____

Due to HIPAA regulations, the use of a member's name on this form is prohibited.

			Member ID (#1)	Member ID (#2)	Member ID (#3)	Member ID (#4)	Member ID (#5)
1	Is chart accessible?	3	0	0	0	0	0
2	Do all pages contain patient ID (name/ID #)?	4	0	0	0	0	0
3	Is there personal/biographical data?	3	0	0	0	0	0
4	Is the provider identified on each entry?	4	0	0	0	0	0
5	Are all entries dated?	3	0	0	0	0	0
6	Is the record legible?	4	0	0	0	0	0
7	**Are significant illnesses and medical conditions indicated on the problem list? ***	3	0	0	0	0	0
8	**Are allergies and adverse reactions to medications prominently displayed or, if patient has no known allergies or history of adverse reaction, is this appropriately noted in the record? ***	3	0	0	0	0	0
9	**Is there an appropriate past medical history in the record (for patients seen three or more times) that includes serious accidents, operations or illnesses, emergency care, and discharge summaries? For members 18 and under, include prenatal care, birth, operations and childhood illnesses. ***	3	0	0	0	0	0
10	Is there documentation of smoking habits, history of alcohol or substance use (age 12 and over), and was the patient counseled if the response was positive?	3	0	0	0	0	0
11	Is there a pertinent history and physical exam?	4	0	0	0	0	0
12	Have lab and other studies been ordered, as appropriate, and do they reflect the primary care physician's review?	4	0	0	0	0	0
13	**Are working diagnoses consistent with findings? ***	3	0	0	0	0	0
14	Do plans of action/treatment appear consistent with diagnoses? *	3	0	0	0	0	0
15	Is there a date for a return visit or other follow-up plan for each encounter?	4	0	0	0	0	0
16	Are problems from previous visits addressed?	3	0	0	0	0	0
17	Is there evidence of appropriate use of consultants?	3	0	0	0	0	0
18	Is there evidence of continuity and coordination of care between primary and specialty physicians?	4	0	0	0	0	0
19	Do consultant summaries, and lab and imaging study results reflect the primary care physician's review?	4	0	0	0	0	0
20	**Does the care appear to be medically appropriate? (There is no evidence that patient was placed at inappropriate risk by diagnostic or therapeutic procedure.) ***	3	0	0	0	0	0
21	Is there a completed immunization record for patients age 13 and under or an appropriate history for adults?	4	0	0	0	0	0

22	Are preventive services appropriately used?	3				0				0				0				0				0
23	Does documentation include: (three points total) A. Is there evidence an advance directive was offered/discussed with patient (21 and older)? B. Is there a signed consent form for release of information by the member?	 1.5 1.5				0				0				0				0				0
24	Does pediatric documentation include: - Growth chart (1.5 pts.) - Head circumference chart (1 pt.) - Development milestones (1.5 pts.)	 1.5 1 1.5				0				0				0				0				0
25	Is there a list of current medications?	4				0				0				0								0
26	If a mental health problem is noted, was a referral made or was treatment performed by the PCP?	3				0				0				0				0				0
27	If a substance use problem is noted, was a referral made or was treatment or education noted?	3				0				0				0				0				0
28	Are abnormal test results acknowledged?	2				0				0				0				0				0
29	Are copies of any emergency treatment and/or hospital admission (including discharge summaries and/or ancillary services care) present in the chart?	1				0				0				0				0				0
30	Is there evidence of provider reporting of communicable diseases and conditions to DOHMH, as required by the New York City Health Code (24 RCNY §§ 11.03-11.07 and Article 21 of the NYS Public Health Law): - Infant/toddler-suspected developmental delays, suspected child abuse/neglect, domestic violence screening, sexual assault and all communicable diseases such as, but not limited to Rabies, Hepatitis C, and HIV. See NYSDOH Communicable Disease Reporting Requirements.	4				0				0				0				0				0
31	Is there evidence that the PCP utilizes a Behavioral Health Questionnaire or a formal assessment tool (PHQ-9) to identify the member's mental health/substance use needs?	1				0				0				0				0				0
32	Is there documentation of HIV/AIDS counseling and recommendations for testing, as well as reinforcement of rapid HIV testing, and availability of free and confidential sites for this service?	0				0				0				0				0				0
		100	0	0	0	0%	0	0	0	0%	0	0	0	0%	0	0	0	0%	0	0	0	0%
*These critical elements must be met, in addition to receiving an average score of 80 percent, to achieve an acceptable rating on the Clinical Medical Record Review.																						
Revised 2/8/2010																					Average 0%	

* These critical elements must be met, in addition to receiving an average score of 80 percent to achieve an acceptable rating on the Clinical Medical Record Review.

Specialty Clinical Medical Record Review

ANTHEM SPECIALTY CLINICAL MEDICAL RECORD REVIEW

Physician Name: _____

First Last

Office Address: _____

Physician Specialty: _____ Date: _____

			Member ID #1				Member ID #2				Member ID #3				Member ID #4				Member ID #5			
		Point Value	Y	N	N/A	Point Score	Y	N	N/A	Point Score	Y	N	N/A	Point Score	Y	N	N/A	Point Score	Y	N	N/A	Point Score
1	Is the chart accessible?	3				0				0				0				0				0
2	Do all pages contain patient ID (name/ID #)?	4				0				0				0				0				0
3	Is there personal/biographical data?	3				0				0				0				0				0
4	Is the provider identified on each entry?	4				0				0				0				0				0
5	Are all entries dated?	3				0				0				0				0				0
6	Is the record legible?	4				0				0				0				0				0
7	**Are significant illnesses and medical conditions indicated on the problem list?***	3				0				0				0				0				0
8	**Are allergies and adverse reactions to medications prominently displayed or, if the patient has no known allergies or history of adverse reaction, is this appropriately noted in the record?***	3				0				0				0				0				0
9	**Is there an appropriate past medical history in the record (for patients seen three or more times) that includes serious accidents, operations or illnesses, emergency care, and discharge summaries? For members 18 and under, include prenatal care, birth, operations and childhood illnesses.***	3				0				0				0				0				0
10	Is there documentation of smoking habits or a history of alcohol or substance use (age 12 and over), and was the patient counseled if the response was positive?	3				0				0				0				0				0
11	Is there a pertinent history and physical exam?	4				0				0				0				0				0
12	Have lab and other studies been ordered, as appropriate, and do they reflect the Primary Care Provider's (PCP's) review?	4				0				0				0				0				0
13	**Are working diagnoses consistent with findings?***	3				0				0				0				0				0
14	**Do plans of action/treatment appear consistent with diagnoses?***	3				0				0				0				0				0
15	Is there a date for a return visit or other follow-up plan for each encounter?	4				0				0				0				0				0

16	Are problems from previous visits addressed?	3				0				0				0				0				0
17	Is there evidence of appropriate use of consultants?	3				0				0				0				0				0
18	Is there evidence of continuity and coordination of care between primary and specialty physicians?	4				0				0				0				0				0
19	Do consultant summaries and lab and imaging study results reflect the PCP's review?	4				0				0				0				0				0
20	**Does the care appear to be medically appropriate? (There is no evidence that the patient was placed at inappropriate risk by diagnostic or therapeutic procedure.)***	3				0				0				0				0				0
21	Is there a completed immunization record for patients age 13 and under or an appropriate history for adults?	4				0				0				0				0				0
22	Are preventive services appropriately used?	3				0				0				0				0				0
23	Does documentation include: (three points total)																					
	- Evidence an advance directive was offered/discussed with patient (21 and older)?	1.5				0				0				0				0				0
	- A signed consent form for release of information by the member?	1.5				0				0				0				0				0
24	Does pediatric documentation include:																					
	- Growth chart (1.5 pts.)	1.5				0				0				0				0				0
	- Head circumference chart (1 pt.)	1				0				0				0				0				0
	- Developmental milestones (1.5 pts.)	1.5				0				0				0				0				0
25	Is there a list of current medications?	4				0				0				0				0				0
26	If a mental health problem is noted, was a referral made or was treatment performed by the PCP?	3				0				0				0				0				0
27	If a substance use problem is noted, was a referral made or was treatment or education noted?	3				0				0				0				0				0
28	Are abnormal test results acknowledged?	2				0				0				0				0				0
29	Are copies of any emergency treatment and/or hospital admission (including discharge summaries and/or ancillary services care) present in the chart?	1				0				0				0				0				0
30	Is there evidence of provider reporting of communicable diseases and conditions to DOHMH, as required by the New York City Health Code (24 RCNY §§ 11.03-11.07 and Article 21 of the NYS Public Health Law): – Infant/toddler-suspected developmental delays, suspected child abuse/neglect, domestic violence screening, sexual assault and all communicable diseases such as, but not limited to: rabies, hepatitis C and HIV. See NYSDOH Communicable Disease Reporting Requirements.	3				0				0				0				0				0
31	Is there evidence that the PCP utilizes a Behavioral Health Questionnaire or a formal assessment tool (PHQ-9) to identify the member's mental health/substance use needs?	1				0				0				0				0				0
32	Is there documentation of HIV/AIDS counseling and recommendations for testing, as well as reinforcement of rapid HIV testing, and availability of free and confidential sites for this service?	1				0				0				0				0				0
		100	**0**	**0**	**0**	**0%**	**0**	**0**	**0**	**0%**	**0**	**0**	**0**	**0%**	**0**	**0**	**0**	**0%**	**0**	**0**	**0**	**0%**

* These critical elements must be met in addition to receiving an average score of 80 percent to achieve an acceptable rating on the Clinical Medical Record Review.

Problem List

Patient Name: _____DOB: _____Gender: _____
PCP: _____OB-GYN: _____

Name of Allergen	Reaction	Side Effect	Date

Problem List	Date of Onset	Date Resolved

Patient Medication List

Patient Name: _____
ID #: _____**DOB:** _____ **Gender**: _____

Name of Allergen	Reaction	Side Effect	Date

Medication List	Dosage	Route	Start	End

Durable Power of Attorney

You can name a durable power of attorney by filling out this form. You can use another form or use the one your doctor gives you. If you name a durable power of attorney, give it to your Anthem network doctor.

I _____, want _____,
(Name) (Name of person I want to carry out my wishes and person's address)

to make treatment decisions for me if I cannot. This person can make decisions when I am in a coma, not mentally able to or so sick that I just cannot tell anyone. If the person I named is not able to do this for me, then I name another person to do it for me. This person is _____ _____.
(Name of second person I want to carry out my wishes, and second person's address)

TREATMENT I DO **NOT** WANT. I do not want (put your initials by the services you do not want):

_____ Cardiac resuscitation (start my heart pumping after it has stopped)
_____ Mechanical respiration (machine breathing for me if my lungs have stopped)
_____ Tube feeding (a tube in my nose or stomach that will feed me)
_____ Antibiotics (drugs that kill germs)
_____ Hydration (water and other fluids)
_____ Other (indicate what it is here)

TREATMENT I **DO** WANT. I want (put your initial by the services you do want):

_____ Medical services
_____ Pain relief
_____ All treatment to keep me alive as long as possible
_____ Other (indicate what it is here)

What I indicate here will happen unless I decide to change it or decide not to have a durable power of attorney at all. I can change my durable power of attorney anytime I wish. I just have to let my doctor know I want to change it or not have it at all.

Signature: _____
Date: _____
Address: _____

Statement of Witness
I am not related to this person by blood or marriage. I know that I will not get any part of the person's estate when they die. I am not a patient in the healthcare facility where this person is a patient. I am not a person who has a claim against any part of this person's estate when they die. Furthermore, if I am an employee of a health facility in which this person is a patient, I am not involved in providing direct patient care to them. I am not directly involved in the financial affairs of the health facility.

Witness: _____
Date: _____
Address: _____

Living Will

You can make a living will by filling out this form. You can choose another form or use the one your doctor gives you. If you make a living will, give it to your Anthem network doctor.

I, (print your name here) _____, am of sound mind. I want to have what I say here followed. I am writing this in the event that something happens to me and I cannot make decisions about my medical care. These instructions are to be used if I am not able to make decisions. I want my family and doctors to honor what I say here. These instructions will tell what I want to have done if 1) I am in a terminal condition (going to die), or 2) I am permanently unconscious and have brain damage that is not going to get better. If I am pregnant and my doctor knows it, then my instructions here will not be followed during the time I am still pregnant and the baby is living.

TREATMENT I DO **NOT** WANT

I do not want (put your initials by the services you do not want):

_____ Cardiac resuscitation (start my heart pumping after it has stopped)
_____ Mechanical respiration (machine breathing for me if my lungs have stopped)
_____ Tube feeding (a tube in my nose or stomach that will feed me)
_____ Antibiotics (drugs that kill germs)
_____ Hydration (water and other fluids)
_____ Other (indicate what it is here)

TREATMENT I **DO** WANT

I want (put your initial by the services you do want):

_____ Medical services
_____ Pain relief
_____ All treatment to keep me alive as long as possible
_____ Other (indicate what you want here)

What I indicate here will happen unless I decide to change it or decide not to have a living will at all. I can change my living will anytime I wish. I just have to let my doctor know that I want to change it or forgo a living will entirely.

Signature (*if minor, signature of parent or guardian)*: _____

Date: _____

Address: _____

Overpayment Refund Notification Form

In order for an overpayment refund to be processed in a timely manner, please submit a completed form with all refund checks and supporting documentation. If the refund check you are submitting is an Anthem check, please include a completed form specifying the reason for the check return.

Provider Name/Contact _____

Contact Number _____

Provider ID _____

Provider Tax ID _____

Subscriber ID _____

DCN Number (Displayed on CCU Letter) _____

Member Name _____

Member Account Number _____

Date of Service: [to] _____

Total Billed Charges: $ _____

Total Check Amount: $_____

Claim Number(s):

Reason for Refund or Check Return:
□ Anthem Letter
□ Contract Rate Change
□ Duplicate Payment
□ Incorrect Member
□ Incorrect Provider
□ Negative Balance
□ Other Health Insurance/Third-Party Liability
□ Payment Error
□ Billed in Error/Adjusted Charge
□ Other: _____

All refund checks should be mailed with a copy of this form to:

Anthem P.O. Box 933657
Atlanta, GA 31193-3657

Once the Anthem Cost Containment Unit has reviewed the overpayment, you will receive a letter explaining the details of the reconciliation. Thank you for completing this Overpayment Refund Notification Form.

Additional Forms

The following forms are available at **https://providers.anthem.com/ny** to download for your use as needed:

Medicare
- CMS Waiver of Liability Statement
- Medicare Advantage Health Risk Assessment Form

Well-Care Forms
- Well-Care Form (Birth–15 months)
- Well-Care Form (18 months–12 years)
- Well-Care Form (13 years–18 years)

Referral and Claim Submission Forms
- Precertification Request Form
- Maternity Notification Form
- CMS-1500 (08-05) Claim Form
- UB-04 Claim Form

Encounter Forms
- Family Practice Encounter Form
- OB-GYN Encounter Form
- Internal Medicine Encounter Form
- Pediatric Encounter Form

Physical Therapy Forms
- Outpatient Therapy Initial Evaluation Form
- Outpatient Therapy Progress Form

Pharmacy Forms
- PA Form for Medical Injectables
- PA Form for Prescription Drugs
- Synagis PA Form

Behavioral Health Forms
- Behavioral Health Outpatient Treatment Form
- Behavioral Health Outpatient Treatment Report C Form
- Request for Authorization — Psychological Testing Authorization Form
- Behavioral Health Neuropsychological Testing Form

Provider Grievance and Appeals
- Provider Payment Dispute and Correspondence Submission

Update and Change Your Information
- Change Information Form

Growth Hormone Clinical Management Forms
- Initial Request Adults Form
- Follow-up Adults Form
- Initial Request Pediatric and Adolescents Form
- Follow-up Pediatrics Form

Screening Tools
- Mental Health and Substance Use Screening Tool

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

CarelonRx, Inc. is a separate company providing utilization review services on behalf of the health plan.

Provider Services: 800-450-8753
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