Anthem Blue Cross and Blue Shield

MyCare Ohio

Provider Manual

Effective January 1, 2026

Anthem

OHBCBS-FDE-PM-088356-25

This page is left intentionally blank.

Click to return to Table of Contents

Table of Contents

Click to return to Table of Contents

Click to return to Table of Contents

Click to return to Table of Contents

Click to return to Table of Contents

Section I: Introduction

Material in this Provider Manual is subject to change. The most up-to-date copy of this Provider Manual can be found at **https://www.anthem.com/oh/provider/state-federal**

Welcome

Welcome! Thank you for being part of Anthem Blue Cross and Blue Shield (Anthem), a Next Generation MyCare Ohio plan. We are excited you have chosen to be part of our network and have committed to providing the best possible care for our MyCare Ohio members, who are at the center of everything we do.

In January 2026, Anthem became a statewide Next Generation MyCare Ohio plan supporting dually eligible members across the state. Ohio Department of Medicaid (ODM) is implementing the Next Generation MyCare program. To allow for a smooth transition, ODM will roll out the Next Generation MyCare program in two phases, beginning with each of the 29 counties where MyCare Ohio is currently available. Statewide expansion of the Next Generation MyCare program will follow as quickly as possible.

Anthem is committed to ODM's goal of improving the health outcomes of the individuals we serve.

This new Next Generation MyCare Ohio program focuses on the individual with strong cross-agency coordination and partnership among Anthem, other MCOs, vendors, sister state agencies, and ODM to support specialization in addressing critical needs.

About This Manual

This provider manual is designed as a guide for groups and individual providers, hospitals, and ancillary providers. Our goal is to create a useful reference guide for you and your office staff. We want to help you navigate our managed healthcare plan to find the most reliable, responsible, timely, and cost-effective ways to deliver quality healthcare to our members.

We recognize that managing our members' health can be a complex undertaking, requiring familiarity with the rules and regulations of a complex healthcare system. With this complexity in mind, we created the manual to address your questions, concerns, and responsibilities before and after an Anthem member walks through your doors.

The information contained in this manual is proprietary. By accepting this manual, providers agree to use this manual solely for the purposes of referencing information regarding the provision of medical services to enrollees who have chosen Anthem as their healthcare plan.

Updates and Changes

The provider manual, as part of your Provider Agreement and related addendums, is subject to change and may be updated at any time. In the event of an inconsistency between information in the manual and the Provider Agreement between you or your facility and Anthem, the Provider Agreement shall govern.

In the event of a material change to the provider manual, we will notify providers 30 days prior to such change through web-posted newsletters and bulletins, email notifications, fax communications, and other mailings. In such cases, the most recently published information should supersede all previous information and be considered the current directive.

This manual is not intended to be a complete statement of all Anthem policies or procedures. Other policies and procedures not included in this manual may be posted on our website or published in specially targeted communications, as referenced above.

Click to return to Table of Contents

This manual does not contain legal, tax or medical advice. Please consult your own advisors for such advice.

HIPAA and PHI

The *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* specifies that Protected Health Information (PHI) can be disclosed for the purpose of healthcare operations in relation to quality assessment and improvement activities. Moreover, the information you share with us is legally protected through the peer review process; as such, it will be maintained in a strictly confidential manner. If you receive a request for medical records, please provide them within 10 days from the date of request.

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

We recognize our responsibility under the *HIPAA* privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose. Conversely, you should only request the minimum necessary member information required to accomplish the intended purpose when contacting us.

However, please note that the privacy regulations allow the transfer or sharing of member information, which may be requested by Anthem to conduct business and make decisions about care, such as a member's medical record, to make an authorization determination or resolve a payment appeal. Such requests are considered part of the *HIPAA* definition of treatment, payment, or healthcare operations.

Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with access restricted to individuals who need member information to perform their jobs. When faxing information to us, verify that the receiving fax number is correct, notify the appropriate staff at Anthem and verify that the fax was appropriately received. Internet email (unless encrypted) should not be used to transfer files containing member information to us (for example, Excel spreadsheets with claim information). Such information should be mailed or faxed. Please use professional judgment when mailing medically sensitive information such as medical records.

The information should be in a sealed envelope marked confidential and addressed to a specific individual, P.O. Box, or department at Anthem. Our voicemail system is secure, and password protected. When leaving messages for our associates, you should only leave the minimum amount of member information required to accomplish the intended purpose. When contacting us, please be prepared to verify the provider's name, address, NPI number, and tax identification number (TIN), or Anthem provider number.

Accessing Information, Forms, and Tools on Our Website

A wide array of tools, information and forms are accessible via the provider website at **https://www.anthem.com/oh/provider/state-federal**. To access additional information on any topic, select from the list of quick links on the left-hand side of the screen.

If you have any questions about the content of this manual, contact Provider Services at **833-727-2170** during our hours of operation: Monday to Friday, 8 a.m. to 8 p.m. ET or via email at ohiomedicaidprovider@anthem.com.

Websites

The Anthem website and this manual may contain links and references to internet sites owned and maintained by third-party sites. Neither Anthem nor its related affiliated companies operate or control, in any respect, any

information, products, or services on third-party sites. Such information, products, services, and related materials are provided **as is** without warranties of any kind, either express or implied, to the fullest extent permitted under applicable laws. Anthem disclaims all warranties, express or implied, including but not limited to implied warranties of merchantability and fitness. Anthem does not warrant or make any representations regarding the use or results of the use of third-party materials in terms of correctness, accuracy, timeliness, reliability, or otherwise.

Click to return to Table of Contents

Section II: Basic Plan Information

Nondiscrimination Policy

Anthem does not engage in, aid, or perpetuate discrimination against any person by providing significant assistance to any entity or person who 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, type of illness or condition, genetic information, military status, etc.

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

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

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

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

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

If you or your patient believes 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: P.O. Box 62429 Virginia Beach, VA 23466
- Provider phone: **833-727-2170**
- Member phone: **833-727-2169 (TTY: 711)**

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 or association with a member of a protected class (that is, 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.

Click to return to Table of Contents

General Contact Information

When you need the correct phone number, fax number, website or street address, the information should be right at your fingertips. With that in mind, we have compiled the most-used contacts for you and your office staff for Anthem services and support.

Anthem and Ohio Department of Medicaid Contacts

If you have questions about...	Contact
Integrated Help Desk	Internal ODM Command Center (IHD) **800-686-1516** 24 hour, 7 days a week access to information regarding provider information related to the PNM. Provider representatives are available via the IVR system weekdays from 8 a.m. through 4:30 p.m. ET. **Please note: For any questions related to claims inquiries, please contact Anthem Provider Services or utilize Availity.**
Provider Services	Anthem Provider Services Phone: **833-727-2170** TTY: **711** Hours: Monday to Friday, 8 a.m. to 8 p.m. ET **Closure days** Provider Services will be closed on the following days: • New Year's Day • Martin Luther King Jr. Day • Memorial Day • Juneteenth • Independence Day • Labor Day • Thanksgiving Day • Friday after Thanksgiving • Christmas Day
Availity Essentials	Availity Essentials: **Availity.com** • Eligibility and Benefits including digital ID cards • Submit a prior authorization request • Check claim status • Check payment status • Electronic Remittance Advice (ERA) • Submit a claim dispute • View authorization status • Submit an authorization appeal on behalf of the member

Click to return to Table of Contents

If you have questions about...	Contact
Behavioral health services	Anthem Provider Services Phone: **833-727-2170** Peer to peer: **844-441-1506** TTY: **711** Hours: Monday to Friday, 8 a.m. to 8 p.m. ET Crisis Line: **833-727-2043** Prior authorization/notification request should be submitted through Availity Essentials at **Availity.com** or by fax. Outpatient Fax (Behavioral Health Only): **866-577-2183** Inpatient Fax and all urgent cases such as Residential Treatment and ACT (Behavioral Health Only): **866-577-2184** If you prefer to paper fax, please use correct forms located on the website at **https://www.anthem.com/oh/provider/state-federal**
Care coordination referrals	Anthem Provider Services Phone: **833-727-2169** TTY: **711** Hours: Monday to Friday, 8 a.m. to 8 p.m. ET Physical health referrals: OHPHCaseManagement@anthem.com Behavioral health referrals: OHBHCaseManagement@anthem.com
Carelon Medical Benefits Management	Phone: **833-500-6966** Hours: Monday to Friday, 8 a.m. to 8 p.m. ET Website: **providerportal.com** or **Availity.com**
Submitting new day and corrected electronic claims via an ODM authorized Trading Partner: electronic processing	Claims submission process: Providers who have an established ODM Trading Partner should submit claims via the Fiscal Intermediary (FI) through their EDI Trading Partner. **Anthem EDI payer ID #**: 0022147: Medical claims Providers who do NOT have an established ODM Trading Partner: • Submit Claims via Direct Data Entry in Availity Essentials under the Claims & Payment menu: **Availity.com** • For additional information related to LTSS HCBS (waiver) claims submission via Availity Essentials, please reference Section 17: Long-Term Services and Supports. Dental, vision, and transportation providers who are contracted through the Anthem delegated vendors should follow the provider manuals for claims submission instructions.

Click to return to Table of Contents

If you have questions about...	Contact
Electronic funds transfer enrollment	**https://enrollsafe.payeehub.org**
Submitting claim disputes	**Online:** Disputes can be submitted through Availity Essentials Claim Status application. Locate your claim and select the dispute button to initiate then select "Go To Request" to complete your dispute. (**Availity.com**) **Mail:** Anthem Blue Cross and Blue Shield Correspondence/ Claim Disputes P.O. Box 62500 Virginia Beach, VA 23466 **By phone:** Provider Services Phone: **833-727-2170** Hours: Monday to Friday, 8 a.m. to 8 p.m. ET
Requesting external medical review	Download the Ohio Medicaid MCE *External Medical Review Request Form* at **www.hmspermedion.com** Submit Form to: Permedion at **https://ecenter.hmsy.com/**
Claim overpayment recovery and refund procedure	To request a recovery, submit *Recoupment Notification Form and Overpayment Refund Notification Form* (located on **https://www.anthem.com/oh/provider/state-federal**) to: Anthem Blue Cross and Blue Shield P.O. Box 933657 Atlanta, GA 31193-3657 Fax: **866-920-1874**
Dental services	Liberty Dental Plan Provider Services: **888-352-7924** Claims and prior authorization/notification requests should be submitted directly to Liberty Dental Plan who then submit to the Fiscal Intermediary. Website: **https://libertydentalplan.com/Providers/Provider-Resource-Library.aspx**

Click to return to Table of Contents

<table>
<tr><th>If you have questions about...</th><th>Contact</th></tr>
<tr><td>Routine vision services</td><td>EyeMed
Phone: 877-497-4626
TTY: 711
Hours:
<table>
<tr><th>Line of business</th><th>Monday – Friday</th><th>Saturday</th><th>Sunday</th></tr>
<tr><td>Government
Apr 1 – Sept 30</td><td>8 a.m. – 2 p.m.</td><td>8 a.m. – 2 p.m.</td><td>11 a.m. – 8 p.m.</td></tr>
<tr><td>Government
Oct 1 – Mar 31</td><td>8 a.m. – 2 p.m.</td><td>8 a.m. – 2 p.m.</td><td>8 a.m. – 2 p.m.</td></tr>
</table>

Claims should be submitted directly to EyeMed who then submit to the Fiscal Intermediary.

Website: www.eyemedinfocus.com</td></tr>
<tr><td>Fraud and Abuse Department</td><td>Anthem phone: 866-847-8247

ODM by phone at 614-466-0722 or online at https://medicaid.ohio.gov/stakeholders-and-partners/helpfullinks/reporting-suspected-medicaid-fraud

Ohio Attorney General's Office Medicaid Fraud Control Unit (MFCU) by phone at 800-642-2873 or online at http://www.ohioattorneygeneral.gov/Individuals-and-Families/Victims/Submit-a-Tip/Report-Medicaid-Fraud and

The Ohio Auditor of State (AOS) by phone at 866-FRAUD-OH or by email at fraudohio@ohioauditor.gov.
Hours: Monday to Friday, 7 a.m. to 8 p.m. ET</td></tr>
</table>

Click to return to Table of Contents

If you have questions about...	Contact
Member Grievances and Member Appeals	With a member's consent, providers can file an appeal of an authorization decision on behalf of their patients in several ways: • Submit an appeal utilizing Interactive Care Reviewer (ICR) via Availity Essentials at **Availity.com**. The member's written consent will need to be uploaded as part of the appeal **Availity.com**. • The *Ohio Standardized Appeal* form can be printed from the provider website **https://www.anthem.com/oh/provider/state-federal**), signed by the member, and faxed directly to the appeals department at **888-458-1406** • Expedited appeals affecting a member's health should be faxed directly to the appeals department at **888-458-1406**, or mailing the form to: **Anthem MyCare:** Medicare Complaints, Appeals & Grievances Mailstop: OH0205-A537 4361 Irwin Simpson Rd Mason, OH 45040 **Anthem MyCare Medicaid only**: Medical Appeals Anthem Blue Cross and Blue Shield P.O. Box 62429 Virginia Beach, VA 23466-2429 Members can also file appeals directly with Anthem by faxing the completed form to **888-458-1406,** calling Member Services at **833-727-2169**, emailing the completed form to ohioga@anthem.com, or mailing the form to: **Anthem MyCare**: Medicare Complaints, Appeals & Grievances Mailstop: OH0205-A537 4361 Irwin Simpson Rd Mason, OH 45040 **Anthem MyCare Medicaid only**: Medical Appeals Anthem Blue Cross and Blue Shield P.O. Box 62429 Virginia Beach, VA 23466-2429

Click to return to Table of Contents

If you have questions about...	Contact
Provider Appeals	Anthem Provider Services Phone: **833-727-2170** TTY: **711** Hours: Monday to Friday, 8 a.m. to 8 p.m. ET Provider appeals can be submitted the following ways: Electronically: Using Availity Essentials at Availity.com Fax: Directly to the Appeals Department at fax **888-458-1406** Mail: Submit the form to: **Anthem MyCare**: Medicare Complaints, Appeals & Grievances Mailstop: OH0205-A537 4361 Irwin Simpson Rd Mason, OH 45040 **Anthem MyCare Medicaid only**: Medical Appeals Anthem Blue Cross and Blue Shield P.O. Box 62429 Virginia Beach, VA 23466-2429

Click to return to Table of Contents

If you have questions about...	Contact
Hospital/facility admission notification	Anthem Provider Services Phone: **833-727-2170** TTY: **711** Hours: Monday to Friday, 8 a.m. to 8 p.m. ET Prior authorization/notification request: please submit through Availity Essentials at **Availity.com**. **MyCare** **Inpatient authorization fax #:** • **877-423-9972** (Physical Health)-concurrent reviews for inpatient and admission requests for SNF/LTAC/Acute Rehab/NF • **866-959-1537** elective admissions **Outpatient authorization fax #:** • **866-959-1537** elective admissions and outpatient services including durable medical equipment and home health services • **800-563-5581** medical injectables • **877-643-0672** (Physical Health)-home health care, physical therapy, occupational therapy, speech therapy, private duty nursing, durable medical equipment, chiropractic and acupuncture **Medicaid (if Medicare benefits have been exhausted)** **Inpatient fax #:** • **877-643-0671** (Physical Health) – concurrent reviews for inpatient and admission request for SNF/LTAC/Acute Rehab/NF **Outpatient fax #:** • **800-964-3627** elective admissions and outpatient surgeries • **800-563-5581** medical injectables • **877-643-0672** (Physical Health)-home health care, physical therapy, occupational therapy, speech therapy, private duty nursing, durable medical equipment, chiropractic and acupuncture
Interpreter services	Anthem Provider Services Phone: **833-727-2170** Anthem Member Services **833-727-2169** TTY: **711** Hours: Monday to Friday, 8 a.m. to 8 p.m. ET. After hours, call 24/7 NurseLine: **855-658-9249** Hours: 24 hours a day, 7 days a week

Click to return to Table of Contents

If you have questions about...	Contact
24/7 NurseLine	Phone: **855-658-9249** TTY: **711** Hours: 24 hours a day, 7 days a week
Member Services	Members can submit grievances and appeals via the member website or through the Sydney Mobile Application or call Member Services to answer questions, make changes or file grievances and appeals, request interpreter services, personal information changes: Phone: **833-727-2169** TTY: **711** Hours: Monday to Friday, 8 a.m. to 8 p.m. ET After hours, call the 24/7 NurseLine: **855-658-9249** TTY: **711** Hours: 24 hours a day, 7 days a week Interpreter Services can also be contacted through Member Services. Sign language, oral interpretation, oral translation, and auxiliary aids, and services must be available for the review of marketing materials at no cost to eligible individuals.
Medical injectable authorization inquiries and requests	Prior authorization/notification request: Online: **Availity.com** Fax: **800-563-5581** Phone: **833-727-2170** *Medical Injectable Drug Criteria*: **anthem.com/ms/pharmacyinformation/clinicalcriteria/home.html** **To determine if a medical injectable Drug requires prior authorization, please visit:** **https://www.anthem.com/oh/provider/state-federal**
Pharmacy Authorization Request	**Medicare Prior authorization request**: Phone: **1-844-521-6938** Fax: **1-833-293-0661** **Online:** **https://www.covermymeds.health/** **https://providerportal.surescripts.net/ProviderPortal/login** Hours: Monday to Friday, 8 a.m. to 9 p.m. ET and Saturday, 10 a.m. to 2 p.m. ET
Nonemergent transportation services: provided through MTM Health	Phone: **888-644-3547 TTY: 711** Hours: 24 hours a day, 7 days a week. Online: **https://mtm.mtmlink.net**

Provider Representative Information

We recognize the challenges you face serving your patients, our members. To make it easy to do business with us, we have designated Provider Experience consultants who will be your point of contact for issues that cannot be resolved using our self-service tools.

Click to return to Table of Contents

Our Provider Relationship Account Management team acts as a liaison and is responsible for onsite orientation, ongoing training, and policy/procedure consultation. They will assist providers with administrative policy and procedure problem resolution and service needs.

To contact a member of the Provider Relationship Account Management team, visit **https://www.anthem.com/oh/provider/state-federal** and select **Contact Us** at the bottom of the home page or email us directly at ohiomedicaidprovider@anthem.com. For additional detail and contact information related to LTSS Provider Relations, see Section 17: Long-Term Service and Supports (LTSS)/Home and Community Based Services (HCBS).

Section III: Provider Resources

Anthem Provider Services

Phone: **833-727-2170**
TTY: **711**
Hours: **Monday to Friday, 8 a.m. to 8 p.m. ET**

Closure days
Provider Services will be closed on the following days:

- New Year's Day
- Martin Luther King Jr. Day
- Memorial Day
- Juneteenth
- Independence Day
- Labor Day
- Thanksgiving Day
- Friday after Thanksgiving
- Christmas Day

Provider Self-Service website

Providers have two web resources available to them when doing business with Anthem.

The first web resource is the Anthem website at **https://www.anthem.com/oh/provider/state-federal**, which offers resources such as:

- Forms
- Provider manual
- Policies
- Education and training
- Provider news
- Claims Payment Systemic Error (CPSE) report

The second web resource is a secure multi-payer website called Availity Essentials, **Availity.com.** Using Availity Essentials, providers can check claim status. Providers will need to be registered with Availity Essentials to access the secure portion of the website. Once signed up, you can log in to a single account and perform numerous administrative tasks for patients covered by us or other selected payers.

Providers may also access Availity Essentials from our website at **https://www.anthem.com/oh/provider/state-federal** by selecting **Login** or **Register**. Detailed information on accessing Availity Essentials is available at **Availity.com** or on our website.

For issues related to accessing Availity Essentials or account creation, contact Availity Client Services at **800-AVAILITY (800-282-4548).**

Provider Policies

Anthem provider polices can be accessed on our website: **https://www.anthem.com/oh/provider/state-federal**. Please refer to the clinical policy and reimbursement policy section for further information.

Click to return to Table of Contents

Reimbursement Policies

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

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

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

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

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

Reimbursement Hierarchy

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

Review Schedule and Updates to Reimbursement Policies

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

Reimbursement by Code Definition

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

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

Outlier Reimbursement Audit and Review Process

Click to return to Table of Contents

Requirements and Policies

The Outlier Reimbursement Audit and Review Process includes the following claim types:

- Claims paid by DRG with an outlier paid at percent of billed charges
- Claims that are paid at percent of billed charges.

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.

Please see link to Reimbursement Policies here: **https://www.anthem.com/oh/provider/state-federal**

In addition to any header in this section, please refer to all other service specific sections which may have more stringent guidelines. There may be multiple sections that apply to any given reimbursable service.

Audits/Records Requests

At any time, a request may be made for on-site, electronic, or hard copy medical records, utilization review documentation and/or itemized bills related to Claims for the purposes of conducting audit or reviews.

Blood and Blood Products

Administration of Blood or Blood Products are not separately reimbursable on inpatient claims. Administration charges on outpatient claims are separately reimbursable when submitted without observation/treatment room charges.

Charges for blood storage and processing, thawing fees charges, irradiation, and other processing charges, are also not separately reimbursable.

Emergency Room Supplies and Services Charges

The Emergency Room level reimbursement includes all monitoring, equipment, supplies, 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. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions (including IV or PICC line insertion at bedside), professional therapy functions, including Physical, Occupational, and Speech call back charges, nursing increments, therapy increments, and bedside respiratory and pulmonary function services. Charges for Outpatient Services for facility personnel are also not separately reimbursable. The reimbursement is included in the payment for the procedure or Observation charge.

Implants

Implants are objects or materials which are implanted such as a piece of tissue, a tooth, a pellet of medicine, a medical device, a tube, a graft, or an insert placed into a surgically or naturally formed cavity of the human body to continuously assist, restore or replace the function of an organ system or structure of the human body throughout its useful life. Implants include, but are not limited to: stents, artificial joints, shunts, pins, plates, screws, anchors, and radioactive seeds, in addition to non-soluble, or solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Instruments that are designed to be removed or

discarded during the same operative session during which they are placed in the body are not implants. In addition to meeting the above criteria, implants must also remain in the Member's body upon discharge from the inpatient stay or outpatient procedure.

Staples, sutures, clips, as well as temporary drains, tubes, similar temporary medical devices and supplies shall not be considered implants. Implants that are deemed contaminated and/or considered waste and/or were not implanted in the Member will not be reimbursed.

IV Sedation and Local Anesthesia

Charges for IV sedation and local anesthesia administered by the provider performing the procedure, and/or nursing personnel, is not separately reimbursable and is included as part of the Operating Room (“OR”) time/procedure reimbursement. Medications used for IV sedation and local anesthesia are separately reimbursable.

Lab Charges

The reimbursement of charges for specimen collection are considered facility personnel charges and the reimbursement is included in the room and board or procedure/Observation charges. Examples include venipuncture, urine/sputum specimen collection, draw fees, phlebotomy, heel sticks, and central line draws.

Processing fees, handling fees, and referral fees are considered included in the procedure/lab test performed and not separately reimbursable.

Labor Care Charges

Reimbursement will be made for appropriately billed room and board or labor charges. Payment will not be made on both charges when billed concurrently.

Nursing Procedures

Fees associated with nursing procedures or services provided by Facility nursing staff or unlicensed Facility personnel (technicians) performed during an inpatient ("IP") admission or outpatient ("OP") visit will not be reimbursed separately. Examples include, but are not limited, to intravenous ("IV") injections or IV fluid administration/monitoring, intramuscular ("IM") injections, subcutaneous ("SQ") injections, IV or PICC line insertion at bedside, nasogastric tube ("NGT") insertion, urinary catheter insertion, point of care/bedside testing (such as glucose, blood count, arterial blood gas, clotting time, etc.) and inpatient blood transfusion administration/monitoring (with the exception of OP blood administration or OP chemotherapy administration which are submitted without observation/treatment room charges.)

Operating Room Time and Procedure Charges

The operating room ("OR") charge will be based on a time or procedural basis. When time is the basis for the charge, it should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the OR nurse’s notes. The operating room charge will reflect the cost of:

- The use of the operating room
- The services of qualified professional and technical personnel

Personal Care Items and Services

Personal care items used for patient convenience are not separately reimbursable on inpatient hospital claims. 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.

Medical Injectable Charges

Click to return to Table of Contents

Medical injectable drugs are covered. 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 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.

Click to return to Table of Contents

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 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 or telemetry unit (step-down units) are included in the reimbursement for the place of service. Additional monitoring charges are not reimbursable.

Time Calculation
- Operating Room ("OR"): Time should be calculated on the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes.
- Hospital/ Technical Anesthesia: Reimbursement of technical anesthesia time will be based on the time the patient enters the operating room (OR) until the patient leaves the room, as documented on the OR nurse's notes. The time the anesthesiologist spends with the patient in pre-op and the recovery room will not be reimbursed as part of the hospital anesthesia time.
- Recovery Room: The reimbursement of Recovery Room charges will be based on the time the patient enters the recovery room until the patient leaves the recovery room as documented on the post anesthesia care unit ("PACU") record.
- Post Recovery Room: Reimbursement will be based on the time the patient leaves the Recovery Room until discharge.

Video or Digital Equipment used in Operating Room
Charges for video or digital equipment used in a surgery are included in the reimbursement for the procedure and are not separately reimbursable. Charges for batteries, covers, film, anti-fogger solution, tapes etc., are not separately reimbursable.

Additional Reimbursement Guidelines for Disallowed Charges
The disallowed charges (charges not eligible for reimbursement) include, but are not limited to, the following, whether billed under the specified Revenue Code or any other Revenue Code. These Guidelines may be superseded by your specific agreement. Please refer to your contractual fee schedule for payment determination.

The tables below illustrate examples of non-reimbursable items/services codes.

Click to return to Table of Contents

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. 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 (cleansing, etc.) Bedpans/Urinals Bed Scales/Alarms Specialty Beds Foley/Straight Catheters, Urometers/Leg Bags/Tubing

Click to return to Table of Contents

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
	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.) 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)

Click to return to Table of Contents

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 Injection (96374, 96379)
0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310	Nursing Procedures
0230	Incremental Nursing – General
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 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

Click to return to Table of Contents

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
	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 Heel/Elbow Protector Burrs Cardiac Monitor EKG Electrodes Vent Circuit Suction Supplies for Vent Patient Electrocautery Grounding Pad Bovie Tips/Electrodes Anesthesia Supplies Case Carts C-Arm/Fluoroscopic Charge Wound Vacuum Pump Bovie/Electro Cautery Unit Wall Suction 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

Click to return to Table of Contents

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
	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

Clinical Practice Guidelines

Providers need the latest research on treating common conditions, such as asthma, diabetes, and hypertension. The *Clinical Practice Guidelines* follow nationally recognized best practices for standards of treatment and give providers a powerful tool in educating our members. The *Clinical Practice Guidelines* are available on our provider website at **https://www.anthem.com/oh/provider/state-federal**. The website offers the most up-to-date clinical resources and guidelines. You can also contact Provider Services at ohiomedicaidprovider@anthem.com or **833-727-2170** Monday through Friday, 8 a.m. to 8 p.m. ET to request a copy.

Please note: Our recommendation of these guidelines is not an authorization, certification, explanation of benefits or a contract. Actual member benefits and eligibility for services are determined in accordance with the requirements set forth by the state. All initial prior authorization requests must be submitted via Availity Essentials at **Availity.com** or by fax.

Preventive Healthcare Guidelines

Good health begins with good lifestyle habits and regular exams. We support providers in helping members take control of their own health by identifying and reducing the risk of potentially serious conditions.

The preventive healthcare guidelines, offered by nationally recognized health organizations as a provider resource, are an effective tool for improving the overall health of our members by emphasizing education and behavior change. The guidelines can soon be accessed from the Anthem provider website **https://www.anthem.com/oh/provider/state-federal**.

Please note: Our recommendation of these guidelines is not an authorization, certification, explanation of benefits, or a contract. Actual member benefits and eligibility are determined in accordance with the requirements set forth by the state. All initial prior authorization requests are required to be submitted to ODM through the PNM Portal or via the EDI gateway through a trading partner.

Communication Listserv Subscriptions

Register to stay in touch and receive all provider communications and our monthly provider newsletter, Provider News, via email. Register now by going to **https://www.anthem.com/oh/provider/state-federal**. You can also sign up to receive ODM news and information by going to: **https://medicaid.ohio.gov/home/govdelivery-subscribe.**

Note: Provider News emails will come from ProviderCommunications@email.anthem.com, so add to your safe sender/recipient list to ensure you will receive our emails.

Claims Payment Systemic Error (CPSE) Report

A claims payment systemic error (CPSE) is defined as the MCOP's claim's adjudication incorrectly underpaying, overpaying, or denying claims that impact five or more providers. A report containing all active CPSEs is updated monthly and can be found here at **https://www.anthem.com/oh/provider/state-federal**.

Forms

The ODM Forms Library is located at:
https://medicaid.ohio.gov/stakeholders-and-partners/legal-and-contracts/forms/forms:

- ***Consent for Hysterectomy Form***
- ***Consent for Abortion Form***
- ***Consent for Sterilization Form***
- ***Standardized Member Appeal Form***
- ***Provider Specific Appeal Form***
- ***SUD Residential Admission Form***
- ***Medicaid Addendum***
- ***Out-of-Network Provider Application***
- ***Medicaid MyCare Ohio Provider Agreement***
- ***Prior Authorization***

Provider Trainings

At Anthem, we are continually developing new ways to work collaboratively with healthcare professionals. The mission of our Provider Experience team is to improve working relationships with our provider partners through the development and delivery of communications and educational programs that foster best practice opportunities. These complimentary programs are also a great way to stay current on changes and updates at Anthem.

The health plan ensures that all new providers receive training regarding Ohio Managed Care and other government-funded programs administered by Medicaid Business. The health plan provides ongoing, and at a minimum annual, education and training to the provider network.

All training materials may be reviewed and are subject to approval by ODM. We post all materials from training sessions to our provider website here: **https://www.anthem.com/oh/provider/state-federal**. Anthem shall maintain a website for use by providers describing the key program elements and requirements, including, at minimum, the information required in the Provider Manual and provider training. Providers are required to attend ODM-delivered provider training as mandated by ODM.

Provider Engagement Council

- Anthem has established a Provider Engagement Council and meetings are held no less than three times per year.
- Provider Engagement Council meetings are offered by phone or webinar.

Click to return to Table of Contents

- Anthem will ensure that all Provider Engagement Council is composed of a wide array of provider types, including both dental and behavior health providers.
- Anthem will use the Provider Engagement Council meetings to gather input, discuss issues impacting providers, identify challenges, and remove barriers. Anthem will work in collaboration with providers to problem-solve, share information, and collectively find ways to improve the healthcare service delivery system.
- Anthem's Provider Engagement Council will be chaired by Chief Executive Officer (CEO) Chief Operation Officer (COO) or their designee.

If you are interested in participating in the Provider Engagement Council, contact: ohiomedicaidprovider@anthem.com.

Medical Advisory Committee

Anthem has established a Medical Advisory Committee (MAC) to:

- Assess levels and quality of care provided to members.
- Recommend, evaluate, and monitor standards of care.
- Identify 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.
- Oversee the peer review process.
- Conduct network maintenance through contracting.
- Advise the health plan administration in any aspect of the health plan policy or operation affecting network providers or members.
- Approve and provide oversight of the peer review process and the Utilization Review Program.
- Approve and make recommendations of the clinical aspects of the Quality Management Program.
- Oversee and make recommendations regarding health promotion activities.
- Use an ongoing peer review system to:
    - Monitor practice patterns.
    - Identify appropriateness of care.
    - Improve risk prevention activities.
- Approve clinical protocols/guidelines.
- Review clinical study design and results.
- Develop action plans/recommendations regarding clinical quality improvement studies.
- Consider/act in response to provider sanctions.
- Oversee member access to care.
- Review and provide feedback regarding new technologies.
- Approve recommendations from subordinate committees.

Participants of Medical Advisory Committee (MAC) include:

- Plan Medical Director
- Plan Behavioral Health Medical Director
- Plan Medical Management Leader
- Plan Quality Management Leader
- Participating providers reflecting the provider network and member base with representation from different specialties

If you are interested in participating in the Medical Advisory Committee, contact: ohiomedicaidprovider@anthem.com.

Click to return to Table of Contents

Section IV: Provider Responsibilities

Provider and Facility Responsibilities

Providers are responsible for:

- Providing the level-of-care and range-of-services necessary to meet the medical needs of members, including those with special needs and chronic conditions
- Coordinating and monitoring recommendations to specialist care
- Providing screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems or disorders
- Coordinating and monitoring recommendations for additional care to specialized behavioral health providers in accordance with state requirements
- Referring patients to subspecialists and subspecialty groups and hospitals for consultation and diagnostics according to evidence-based criteria for such recommendations for additional care as it is available
- Obtaining authorization for non-emergency services as appropriate
- Maintaining the continuity of care
- Assuring all medically necessary services are made available in a timely manner
- Providing services ethically and legally and in a culturally competent manner
- Monitoring and following up on care provided by other medical service providers for diagnosis and treatment
- Maintaining a complete and accurate medical record of all services rendered by the provider and other providers by documenting all care rendered
- Communicating with members about treatment options available to them, including medication treatment options regardless of benefit coverage limitations
- Providing hours of operation for members that are no less than the hours of operation offered to any other patient
- Arranging for coverage of services to assigned members 24 hours a day, 7 days a week in person or by an on-call practitioner
- Offering evening and Saturday appointments for members (strongly encouraged for all PCPs)
- Continuing care in progress during and after termination of the provider contract for up to 60 days (up to 90 days if the member is receiving inpatient services) until a continuity of care plan is in place to transition the member to another provider or through postpartum care for pregnant members in accordance with applicable state laws and regulations.
- Discussing advance directives with all members as appropriate
- Providing covered services in the most cost-effective, clinically appropriate setting and manner. In addition, provider must utilize participating providers, and when medically necessary or appropriate, refer and transfer members to participating providers for all covered services, including but not limited to specialty, laboratory, ancillary and supplemental services

Providers have the right to:

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

Click to return to Table of Contents

- Be supported by the organization to make decisions interactively with patients regarding their healthcare.
- Receive courteous and respectful treatment from Anthem staff.
- Communicate complaints regarding condition care as outlined in the Anthem provider complaint and grievance procedure.
- Anthem will not require providers to perform any treatment or procedure that is contrary to the provider's conscience, religious beliefs, or ethical principles in accordance with *42 C.F.R.438.102*.

Provider Maintenance

The Ohio Medicaid provider network management (PNM) system serves as the system of record for provider data for ODM and the MCOPs. As a result, data in the PNM system is used in claims payment, the MCOP's provider directory, and ODM provider directory. To ensure provider information remains current, it is important for providers to keep their information up to date in the PNM system. Please remember, as an ODM provider and in accordance with your provider agreement, providers are responsible for notifying ODM of changes within 30 days (see OAC 5160-1-17.2 (F)).

Updating the PNM system:

- When there is a change in a provider's information, providers must log in to the PNM system, choose the provider you are editing, and click the appropriate button to begin an update. Self-service functions include, but are not limited to:
    - location changes,
    - specialty changes, and
    - key demographic (e.g., name, NPI, etc.) changes.
- Once information is accepted into the PNM system, accepted information is sent to the MCOPs daily for use in their individual directories. The provider must update their information in the PNM system first before the MCOPs are able to make changes to their directory. MCOPs are required to direct providers back to the PNM system if there are changes.
- Not all changes happen automatically. Some self-service updates/changes require ODM staff review and approval before they are saved to the provider's record. Providers should validate if a change has been accepted/ updated in PNM before expecting it to show up for the MCOP. For a list of updates that are automatic versus manual please see the **Updating a Provider File Quick Reference Guide**.

Privacy and Security

Anthem's latest *HIPAA*-compliant privacy and security statement may be found on our website: **https://www.anthem.com/oh/provider/state-federal**. To access this statement, select **Privacy Policy** at the bottom of the provider page.

Throughout this manual, there are instances where information is provided as a sample or example. This information is meant to illustrate and is not intended to be used or relied upon.

There are also places within the manual where you may leave the Anthem site and link to another site operated by a third party. These links are provided for your convenience and reference only. Anthem and its subsidiary companies do not control such sites and do not necessarily endorse these sites. Anthem is not responsible for content, products, or services.

When you link from the Anthem site to another site, you will be subject to the privacy policies (or lack thereof) of the other sites. We caution you to determine the privacy policy of such sites before providing any personal information.

Click to return to Table of Contents

Anthem uses the secure email encryption tool to ensure that members' protected health information is kept private and secure. Secure email encrypts emails and attachments identified as potentially having protected health information. Providers also can use secure email to send encrypted email to Anthem.

Misrouted Protected Health Information

Providers and facilities are required to review all member information received from Anthem to ensure no misrouted Protected Health Information (PHI) is included. Misrouted PHI includes information about members that a provider or facility is not treating. PHI can be misrouted to providers and facilities by mail, fax, email, or electronic remittance advice. Providers and facilities are required to immediately contact Anthem. Anthem is required to inform Ohio Department of Medicaid Privacy Officer promptly of any security incident/breach. Once all required information regarding the misrouted PHI is provided to Anthem, providers and facilities are to destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or re-disclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, please contact Provider Services.

Provider Obligations for Oral Translation, Oral Interpretation, and Sign Language Services

Sign language, oral interpretation, oral translation, auxiliary aids and services must be available at no cost to eligible individuals.

Anthem will also offer limited provider-office based Language Line Kiosks that foster health equity for non-English speaking members through on-demand video and audio interpreters/translators.

Culturally and Linguistically Appropriate Services

Cultural competency information as well as languages spoken by office location will be collected in ODM's Provider Network Management (PNM) system and will be utilized to populate ODM's centralized provider directory. Additionally, this information for credentialed providers will be transmitted to the MyCare Ohio Plans on a weekly basis for them to align their directories with the information contained in the PNM.

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.

Click to return to Table of Contents

- 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. We encourage providers to access and utilize the following resources.

American Medical Association:

- **https://www.ama-assn.org/delivering-care/health-equity/3-ways-mitigate-implicit-bias-exam-room**
- **https://www.ama-assn.org/delivering-care/health-equity/3-ways-battle-unconscious-bias**

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

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

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

Procedure to Notify Anthem of Changes to Provider Demographics

Updating Demographic Data with Anthem

It is critical that members receive accurate and current data related to provider availability. Providers must notify ODM's Provider Network Module (PNM), which acts as ODM's Central Credentialing website of any demographic changes. All requests must be received 30 days prior to change/update. Any requests received within less than 30 days' notice may be assigned a future effective date. Contractual terms may supersede effective date request.

Important: If updates are not submitted 30 days prior to the change, claims submitted for members may be the responsibility of the provider.

Types of demographic data updates can include, but are not limited to:

- Accepting new patients
- Address – additions, terminations, updates (including physical and billing locations)
- Email address
- Handicapped accessibility
- Hospital affiliation and admitting privileges
- Languages spoken
- License number
- Name change (provider/organization or practice)
- National provider identifier (NPI)
- Network participation
- Office hours/days of operation
- Patient age/gender preference

Click to return to Table of Contents

- 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
- Telehealth services

Please note, effective October 1, 2022, credentialing will be handled by ODM and that will be the primary source of practice information for the Medicaid line of business. Anthem will still require providers to submit rosters to Anthem for any other line of business that they are contracted.

Additionally, Next Generation MyCare Ohio waiver providers are responsible for ensuring accurate and up-to-date certification and demographic information through the Ohio Department of Aging. For additional information related to maintaining LTSS waiver provider data, please see Section 17: Long-Term Services and Supports (LTSS)/Home and Community Based Services (HCBS).

For notices of termination from an Anthem network, providers and facilities should refer to the termination clause in the agreement for specific notification requirements. Please allow the number of days' notice of termination from Anthem's network as required by the agreement (for example, 90 days, 120 days, etc.).

Procedure to Notify Anthem of Changes in Member Circumstances

Often providers are the first to learn about changes in member circumstances that may impact their health care needs. Providers may contact Provider Services at **844-912-1226, TTY: 711**, Monday to Friday from 7 a.m. to 8 p.m. ET to notify the health plan of such changes. The Provider Services team will ensure that members are referred to Case Management, or other additional services, as needed.

Providers are also encouraged to utilize the Community Resource Link (FindHelp), **The Community Resource Link by findhelp - Search and Connect to Social Care**, as a resource to refer Anthem members to community organizations that address SDoH needs.

Referring to Non-Participating Providers

Anthem's mission is to provide affordable quality healthcare benefits. Members access their highest level of healthcare benefits from network/participating providers and facilities. Providers and facilities put members at risk of higher out of pocket expenses when they refer to non-participating providers in non-emergent situations or without Anthem's prior approval. Anthem has established maximum allowed amounts for services rendered by non-participating providers. Once Anthem determines the appropriate maximum allowed amount for services provided by a non-participating provider, the payment will be remitted to the member in most situations rather than the non-participating provider, and **Members may not be balance-billed by any provider (participating or non-participating) for the difference between the amount they charge for the service and the amount paid to that non-participating provider**.

Providers are reminded that pursuant to their *Agreement* with Anthem they are generally required to refer members to other network/participating providers. Providers who establish a pattern of referring members to non-participating providers may be subject to disciplinary action, up to and including termination from the network. Anthem understands that there may be instances in which providers must refer to non-participating providers. Providers must present evidence of extenuating circumstances in the event that a provider elects to dispute these. For additional information on participating provider and non-participating provider referrals, providers should refer to the applicable sections of their *Agreement* with Anthem. Both participating and nonparticipating providers are required to submit claims to an ODM EDI authorized trading partner or via Direct Data Entry through Availity at **Availity.com**.

Click to return to Table of Contents

Claims Submission Process for Noncontracted Providers

To be reimbursed for services by Anthem, providers must complete Ohio Medicaid's provider enrollment process. To begin the process, visit. https://medicaid.ohio.gov/resources-for-providers/enrollment-and-support/enrollment-and-support

Anthem will pay out of network providers in the following circumstances for claims submitted within 365 days from the Anthem member's date of service (DOS) and/or date of discharge (DOD):

- **Federally Qualified Health Centers/Rural Health Clinics** — Anthem will provide payment by procedure code in an amount no less than 100% of the Medicaid Fee-for-Service (FFS) rate
- **Out-of-Network Emergency Services** — In accordance with *42 CFR 438.114 and OAC rule 5160-26-03*, Anthem will reimburse out of-network providers of emergency services the lesser of billed charges or 100% of the current Medicaid FFS rate.
- **Out-of-Network Hospital Referrals** — In accordance with OAC rule *5160-26-03*, if ODM approves a member's referral to certain out-of-network hospitals, Anthem will reimburse the hospital at 100% of the current Medicaid FFS rate.
- **Out-of-Network Providers During Transition** — Anthem will reimburse out-of-network providers who provide services during the transition at 100% of the current Medicaid FFS rate.
- **Out-of-Network Qualified Family Planning Providers** — In accordance with OAC rule *5160-26-03*, Anthem will reimburse an out-of-network qualified family planning provider for all Title X services provided to a member that are medically necessary covered services (including on-site diagnostic services) at the lesser of billed charges or 100% of the current Medicaid FFS rate.

Continued Access to Care

New Anthem members may receive services from out-of-network Medicaid-certified providers if certain guidelines are met. First, the provider must contact us to discuss the scheduled health services in advance of the service date. Second, the case must meet medical necessity.

Continuity of Care Process

Anthem's care coordination team promote continuity of care and integration of services for the member across a range of settings, including transitions of care. The interventions specified in the member's care plan provides the optimal benefit to address the multi-dimensional care needs of our members and to increase access to care, which is critical to achieve continuity of care. Anthem's care coordination team is here to assist members in the event they would like to change providers. The team will communicate with the current provider to ensure all care needs are met across the care continuum and care transitions with the new provider.

Continuity of Care

Anthem provides continuity of care for members with qualifying conditions when healthcare services are not available within the network or when the member or provider is in a state of transition.

Anthem must provide the following services to the member regardless of whether services were prior authorized/pre-certified or the treating provider is in or out-of-network with Anthem.

Qualifying condition: A medical condition that may qualify a member for continued access to care and continuity of care

Qualifying conditions include but are not limited to:

- Ongoing chemotherapy or radiation treatment
- Hospital treatment (if member was released from hospital 30 calendar days prior to enrollment); and

Click to return to Table of Contents

- Private duty nursing, home care services, and durable medical equipment (DME) must be covered at the same level with the same provider as previously covered until Anthem conducts a medical necessity review and renders an authorization decision pursuant to *OAC rule 5160-26-03.1*.
- Dialysis
- Transplants
- Surgical care plan until treatment is completed
- Physical therapy/Occupational therapy/Speech therapy for 60 days
- Hospice
- Post Emergency Room care
- Pregnant member to continue with an out-of-network provider if the member is in her third trimester of pregnancy and/or has an established relationship with an obstetrician and/or delivery hospital

States of transition may be when the member is:

- Newly enrolled.
- Moving out of the service area.
- Disenrolling from Anthem to another health plan.
- Exiting Anthem to receive excluded services.
- Hospitalized on the effective date of transition.
- Transitioning through behavioral health services.
- Scheduled for appointments within the first month of plan membership with specialists; these appointments must have been scheduled prior to the effective date of membership.

A state of transition also is applicable when the provider's contract terminates.

Anthem providers help ensure continuity and coordination of care through collaboration. This includes the confidential exchange of information between PCPs and specialists as well as behavioral health providers. In addition, Anthem coordinates care when the provider's contract has been discontinued to facilitate a smooth transition to a new provider.

Anthem assigns a representative to coordinate services with public health agencies or treatment programs within Anthem's service area that are not included in Anthem's network. These include county health agencies, crisis intervention agencies, community support programs, comprehensive community service programs or inpatient programs. Anthem works with the agency to coordinate the member's transition to or from covered mental health and substance use care within Anthem's network. Any member transitioning from crisis intervention services may access an appropriate level of ongoing care within 30 days of the crisis. Anthem is not required to pay for ongoing services outside the Anthem network, unless Anthem has authorized those services.

Providers must maintain accurate and timely documentation in the member's medical record, including but not limited to:

- Consultations.
- Prior authorizations.
- Treatment plans.

All providers share responsibility in communicating clinical findings, treatment plans, prognosis, and the member's psychosocial condition as part of the coordination of care process. Medical management nurses review member and provider requests for continuity of care. These nurses facilitate continuation with the current provider until a short-term regimen of care is completed, or the member transitions to a new provider.

Please note: Only Anthem can make adverse determination decisions regarding continuity of care.

Click to return to Table of Contents

Adverse determination decisions are sent in writing to the member and provider within two business days of the decision. Members and providers may appeal the decision by following the procedures in **Grievances and appeals section.** Reasons for continuity-of-care denials include but are not limited to:

- Course of treatment is complete.
- Member is ineligible for coverage.
- Condition is not a qualifying condition.
- Request is for change of PCP only and not for continued access to care.
- Requested services are not covered.
- Services rendered are covered under a global fee.
- Treating provider currently is contracted with our network.

Except for members who are hospitalized at the time of initial enrollment, Anthem is responsible for all covered pre-existing medical conditions as of the effective date of the member's Medicaid eligibility.

Provider Contract Termination

Anthem will arrange for continuity of care for members affected by a provider whose contract is terminated. A terminated provider actively treating members must continue to treat members until the date of termination. PCPs must give at least 180 days advance notice, and specialists must give at least 180 days advance notice before terminating the Provider Agreement.

After Anthem receives a provider's notice to terminate a contract, we notify all impacted members. We send a letter at least 45 days in advance to inform the affected members about the:

- Impending termination of their provider.
- Member's right to request continued access to care.
- Member Services phone number to make PCP changes and/or forward referrals to Medical Management for continued access-to-care consideration.

Members under the care of specialists also may submit requests for continued access to care, including continued care after the transition period. Members should contact Member Services.

Newly Enrolled Members

Our goal is to ensure that the healthcare of our newly enrolled members is not disrupted or interrupted. Anthem ensures continuity of care for our newly enrolled members when the member's health or behavioral health condition has been treated by specialists. We also ensure continuity of care when the member's health could be placed in jeopardy if medically necessary covered services are disrupted or interrupted.

Anthem will pay a newly enrolled member's existing out-of-network provider for medically necessary covered services until that regimen of care is completed. The member's records, clinical information and care are transferred to an Anthem provider.

Payment to out-of-network providers is made within the same time period required for providers within the network. In addition, we comply with out-of-network provider reimbursement rules as adopted by ODM.

All new enrollees receive evidence-of-coverage (EOC) membership information in their enrollment packets, which provides information regarding members' rights to request continuity of care.

Members Moving Out of The Service Area

If a member moves out of the service area, Anthem will continue to provide emergency services until the member chooses a new managed healthcare plan.

Click to return to Table of Contents

Second Opinions

Anthem will help to ensure that members have access to a second opinion regarding any medically necessary covered service. When the request involves care from a specialist, a provider of the same specialty must give the second opinion. When no provider exists within the network who meets the qualification, Anthem may authorize a second opinion by a qualified out-of-network provider. This service is provided at no cost to the member.

Emergency Dental Services for Adults

Emergency dental care is an immediate service that must be provided to relieve the member from pain, an acute infection, swelling, trismus, fever, or trauma. The nature of the emergency must be documented in the member's medical record.

Clinical Data Sharing

Anthem requires providers and facilities to submit clinical data when requested. For details on how to submit clinical data, review the administrative policy by visiting **https://www.anthem.com/oh/provider/state-federal** and select Clinical Data Sharing.

Health Information Exchange (HIE)

Electronic Health Records

Anthem has invested in advanced digital solutions and understands that this adaptation is necessary to support and strengthen provider relationships. Anthem is focused on expanding connectivity for electronic health record (EHR) vendors and health information exchanges (HIEs) to enhance the Care Coordination experience and improve health outcomes. In addition, Anthem will offer financial incentives as well as grants to encourage rural and under-served providers within the state to adopt electronic health records. Health information exchange (HIE) vendors include but are not limited to:

- CliniSync.

Providers are encouraged to adapt EHR during initial contracting with Anthem and during annual visits. The benefits of EHR include, but are not limited to improved care coordination, notification of admission, ER visits, etc.

Anthem will utilize EHR data in real time to improve outcomes for providers and for our members. Benefits of doing so include, but are not limited to:

- More efficient than faxing medical records.
- Less administrative burden for providers and office staff.
- All codes that are in the EMR system will be included in the data exchange to Anthem.
- Improved individual provider (value-based providers) and group HEDIS® scores by closing gaps in care.
- Decreases health plan's requests for medical records.
- Reduce copy service vendor utilization and requests.
- Provider staff are not displaced from daily office tasks to fulfill requests.
- Trained and proficient HEDIS staff are used which reduces copy errors.

Other possible resources for data can be identified while researching the medical record:

- Closing member gaps in care
- Allows for predictive modeling approach to determine areas of concern for members, which can be shared with their providers
- Reducing claim and authorization questions and denials.

Anthem's network providers are required to support Anthem by providing electronic data exchange including, but not limited to, admission, discharge, and transfer (ADT) data, daily census, confirmed discharge date and

other relevant clinical data. Anthem includes this requirement in the provider manual for provider awareness. Anthem will also educate providers who are non-compliant with this requirement during our regular Joint Operational Committee (JOC) calls. The Provider Experience team can offer assistance to help the providers become compliant.

Anthem will analyze and submit reporting demonstrating our collaboration with providers to utilize EHR.

Medical Records Submission

Solicited Medical Records Submission: When additional medical records are being submitted in response to Anthem's request, the recommended method is to submit them electronically via Availity Essentials using the Medical Attachments tool following the directions below. The Medical Attachments tool supports .tiff, .jpg and pdf attachment file types.

A provider organization's Availity administrator should complete the following set up steps to authorize user access to the Medical Attachments tool:

- From My Account Dashboard, select **Enrollments Center**.
- Medical Attachments Setup, follow the prompts and complete the following sections:
    1. Select **Application** — Choose **Medical Attachments Registration**.
    2. Provider Management — Select **Organization** from the drop-down:
        - Add NPIs and/or Tax IDs. (Both are recommended)
        - Multiples can be added separated by spaces or semi-colons.
    3. Assign user access by checking the box in front of the user's name. Users may be removed by unchecking their name.

To submit supporting documentation in response to a solicited request:

- Log in to Availity Essentials
- Select **Claims and Payments** > Claim Status and locate claim for requested document. Select the Attachment button
- Add supporting documentation and reason
- Submit. If Availity set-up has not been completed and medical records must be sent via mail or fax, send them to the appropriate department as directed in the notification from Anthem. Always include a copy of the request letter on top of the records. Do not place a copy of the Claim on top of the records.
- Track your attachment submission under Claims and Payments > Attachment New.
- If providers are submitting X-rays, pictures, or dental molds, remember to include a valid and complete member identification number on page one of the materials sent with these items.

A provider organization's Availity administrator should complete the set-up steps listed above in Solicited Medical Records Submission section to authorize user access to the Medical Attachments tool.

To submit a solicited attachment, use the instructions below for uploading to Availity Essentials.

The document control number used for solicited attachments is the claim number for the previously submitted claim. If sending an attachment using the EDI 275 through ODM the document control number in the TRN02 segment will also be the claim number for the previously submitted claim:

- Log in to Availity Essentials
- Select **Claims & Payments** > Attachments — New
- **Locate and track in the Attachment New Dashboard. Once the attachment has been accepted, it will move to the History tab.**

Click to return to Table of Contents

To determine what medical records or portion of the medical records may be required, refer to the applicable Anthem Medical Policy, Anthem Clinical Guideline, or Milliman Care Guidelines (MCG) at **https://www.anthem.com/oh/provider/state-federal**. Review the *Position Statement* section of the Anthem Medical Policies or the Clinical Indications section of the applicable Anthem policy to determine what medical records are needed. Refer to the Medical Policies, Clinical Guidelines, sections of the Provider Manual for details on accessing this information.

Unsolicited Medical Records Submission: Unsolicited Medical Records with a claim can be uploaded to Availity Essentials Attachment New application when a paperwork (PWK) segment is submitted with the electronic claim. Electronic claims with the PWK segment should be submitted to Availity Essentials using the MyCare Ohio payer ID 0022147. Once the PWK is received, a card will remain in the Attachment New Dashboard Inbox for 7 calendar days for you to upload your document.

For unsolicited attachments, the document control number is created by the provider organization.

If sending an unsolicited attachment using the EDI 275 through ODM the document control number in the TRN02 segment will match the number submitted in the PWK segment.

When submitting medical records that are not requested by Anthem, include a clear description of the billed code submitted with the claim to help ensure prompt processing of the claim for all miscellaneous, not otherwise classified (NOC), not otherwise specified (NOS), and unlisted HCPCS and CPT codes.

If you want to submit records in support of an underpaid or denied claim, you can do so using the Availity Essentials payment dispute tool.

Coordination of Benefits

If a member or eligible dependent is covered by more than one Health Benefit Plan, the carriers involved work together to prevent duplicate payments for any services. This cooperative effort is called Coordination of Benefits (COB), a provision in most Health Benefit Plans.

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.

The 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.

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

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

- EMR connections

Digital functionality 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 and Network Management
- 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.

Click to return to Table of Contents

- 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 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:
    - The Availity Essentials multi-payer Authorization application facilitates 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

<u>Claim submissions status and claims payment disputes</u>

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.

Click to return to Table of Contents

- Availity Essentials: Claims & Payments application
    - The Claims & Payment application enables Providers and Facilities to enter a Claim directly into an online Claim form and upload supporting documentation for a defined Claims.
    - The Claim status application enables Providers and Facilities 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 they are integrated.
- Provider desktop integration via B2B APIs:
    - Anthem has also enabled real-time access to Claim Status via APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

Claim attachments

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

- EDI transaction: X12 275 – Patient information, including HL7 payload attachment:
    - Anthem supports the industry standard X12 275 transaction for electronic transmission of supporting Claim documentation including medical records via the HL7 payload.
- Availity Essentials – Claim Status application
    - The Claim Status application enables Providers and Facilities 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 their 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 by, reducing administrative processes. There are several options to receive claims payments electronically.

Click to return to Table of Contents

- **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.

Click to return to Table of Contents

Section 6: Provider Enrollment and Network Management – *Applies to Medicare only*

Provider Enrollment

Simplified enrollment process: Providers and Facilities can enroll as a new care provider in our network for professional, ancillary, institutional and facility provider types through Availity Essentials. **Real-Time Tracking**: Providers and Facilities can track the status of their requests in the **My Dashboard** section of the Provider Enrollment and Network Management application.

Contract Changes

Streamlined Contract Change Requests: Providers and Facilities can easily submit certain requests for contract changes through Availity Essentials:

- Amendments requests to add a network or line of business
- Change of Ownership notice
- Contract, line of business, or Network Termination requests
- TIN Change

Real-Time Tracking: Providers and Facilities can track the status of their requests in the **My Dashboard** section of the Provider Enrollment and Network Management application.

Click to return to Table of Contents

Section V: Provider Enrollment, Credentialing, and Contracting

Overview

Enrollment, credentialing, and contracting are distinct yet interconnected processes. Enrollment with ODM is the initial step where providers formally join the Medicaid program. Enrollment occurs through ODM PNM system. If required, credentialing follows, requiring providers to verify their qualifications and expertise through documented evidence, ensuring they meet the necessary standards and possess the required skills. Credentialing is done through ODM. Finally, contracting involves establishing a formal agreement that outlines the specific responsibilities and expectations of both parties, ensuring clarity and mutual understanding in the professional relationship. Contracting is done through MCOP. These steps collectively ensure that providers are appropriately integrated and recognized within the Anthem MyCare Ohio network.

Please note, for Medicare credentialing information, please refer to section 6: Provider Enrollment and Network Management.

Provider Enrollment (ODM Functions)

General provider information/enrollment information:

- In accordance with the Code of Federal Regulations, 42 CFR 438.608, provider enrollment with the state Medicaid agency is required to be reimbursed by the state's contracted MCOP. MCOPs are not allowed to contract with providers who are not enrolled with ODM. ODM does not have reciprocity agreements with other state Medicaid agencies or Centers for Medicare and Medicaid Services (CMS). Enrollment with the ODM is necessary even if you are enrolled with Medicaid in another state or Medicare. The enrollment process can be completed online by visiting: **ODM Enrollment Process**.
- If you do not want to become a fully enrolled provider with ODM, but want to serve Ohio Medicaid beneficiaries, please complete the **MCP Single Case Agreement** in the provider network management (PNM) system or use the **ODM 10295 single case agreement form** . If you use online enrollment in PNM, and you want your provider enrollment span to only be 120 days, you must call ODM and ask that your enrollment be truncated. The ODM 10295 form provides a 120-day agreement with Ohio. Note that multiple single case agreements are not allowed per 42 CFR 438.602.
- 42 CFR 438.602 also requires ODM to screen, enroll, and revalidate MCOP network providers. This law does not require MCOP network providers to render services to fee-for-service (FFS) members. Screening is like a background check to make sure a provider is qualified and credible. Revalidation is a regular check-up to confirm that the provider still meets all the necessary standards and rules over time.
- Organizational provider types will be required to pay an enrollment fee. The fee does not apply to individual providers and practitioners or practitioner groups. The fee is a federal requirement described in 42 CFR 455.460 and in OAC 5160-1-17.8. The fee for 2025 is $730 per application and is not refundable. The fee will not be required if the enrolling organizational provider has paid the fee to either Medicare or another state Medicaid agency within the past five years. However, ODM will require that the enrolling organizational providers submit proof of payment with their application.

Integrated Help Desk/ODM Provider Call Center

- If you have questions or need assistance with your Ohio Medicaid provider enrollment, call the ODM Integrated Helpdesk at 800-686-1516 through the interactive voice response (IVR) system. It provides 24-hour, 7 days a week access to information regarding provider information. Provider representatives are available via the IVR system on weekdays from 8:00 a.m. through 4:30 p.m.
- There are many resources available on the Ohio Department of Medicaid website about the requirements to become a participating provider. Please visit for several useful documents that answer relevant questions.
- **https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/enrollment-and-support/enrollment-and-support**

Click to return to Table of Contents

Termination, Suspension, or Denial of ODM Provider Enrollment

- For a list of termination, suspension and denial actions initiated by ODM against a provider or applicant that allow for hearing rights, please refer to Ohio Revised Code 5164.38.
- For a list of termination, suspension and denial actions initiated by ODM against a provider or applicant that allow for reconsideration, please refer to Ohio Administrative Code rule 5160-70-02.

Loss of Licensure

- In accordance with Ohio Administrative Code rule 5160-1-17.6, a Medicaid provider agreement will be terminated when any license, permit, or certification that is required in the provider agreement or department rule has been denied, suspended, revoked, not renewed or is otherwise limited and the provider has been afforded the opportunity for a hearing in accordance with the hearing process established by the official, board, commission, department, division, bureau, or other agency of state or federal government.

Enrollment and Reinstatement After Termination or Denial:

- If a provider's Medicaid provider agreement is terminated or an applicant's application is denied, the applicant/provider should contact Ohio Medicaid via the Provider Enrollment Hotline **(800-686-1516)** to discuss the requirements to reapply. This process may include conversations with the ODM Compliance unit who will provide specific instruction on re-instatement requirements, if applicable.

Helpful Information

Medicaid Provider Resources

- ***https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/enrollment-and-support/enrollment-and-support***

Federal guidelines for enrollment and screening (42 CFR 455 Subpart E)

- ***https://www.law.cornell.edu/cfr/text/42/part-455/subpart-E***

Ohio Revised Code

- ***https://codes.ohio.gov/ohio-revised-code/chapter-5160***
- ***https://codes.ohio.gov/ohio-revised-code/chapter-3963***

Ohio Administrative Code: Ohio Department of Medicaid

- ***https://codes.ohio.gov/ohio-administrative-code/5160***

Credentialing/Recredentialing (ODM Function)

General provider credentialing and recredentialing

- ODM is responsible for credentialing all Medicaid managed care providers. The credentialing and recredentialing processes are paired with enrollment and revalidation, respectively, in the PNM system. This process adheres to the National Committee for Quality Assurance (NCQA) and CMS federal guidelines for both processes and the types of providers who are subject to the credentialing process.
- Providers are not able to render services to Medicaid members until they are fully screened, enrolled, and credentialed (if required) by Ohio Medicaid. For a complete list of provider types that require credentialing, please refer to OAC rule 5160-1-42.

Click to return to Table of Contents

- For individual providers, the general guidance is that licensed providers who can practice independently under state law are required to go through this process. Medical students, residents, fellows, and providers who practice strictly in an inpatient setting are exempt from credentialing.
- It is recommended that you begin the contracting process with each MCOP you wish to participate with while you are enrolling and being credentialed at ODM, in order to be able to render services as of your effective date. While the credentialing process is being centralized at the state Medicaid level, you are still required to contract with the MCOPs.
- When you submit your initial application to be an Ohio Medicaid provider, you can designate MCOP interest in the PNM system. Once your application is submitted, demographic data for your provider is transmitted automatically to the MCOPs so they can start contracting with you.

Provider Contracting with Anthem

Anthem has established a provider contracting process to ensure a comprehensive provider network that meets the needs of members. Please note, if you want to participating in our Medicare program, you must credential with Anthem as well (not just ODM). For more information on this process, please go to our provider website and click '**join our network.**' The network will be supported by written contracts between Anthem and providers and monitoring will occur to ensure compliance and corrective action plan, as necessary. if you have any questions, contact Provider Services at **833-727-2170, TTY: 711**, Monday to Friday from 8 a.m. to 8 p.m. ET.

Contracting Procedures

- Provider contacts Anthem requesting to join the network. Anthem may also contact providers directly should additional recruitment, to improve access, be needed.
- Anthem will confirm using ODM files that the provider is currently enrolled as an approved Medicaid provider.
- If applicable, contracts will be created and sent to providers for review and signature.
- Upon receipt of signed agreement, Anthem will review, countersign, and send provider information to be loaded into Anthem systems.
- Provider will be sent a welcome letter as well as a copy of their executed Agreement with Anthem.

Medicaid Addendum

The ODM Medicaid Addendum supplements the Base Contract or Agreement between the MCOP and provider and runs concurrently with the terms of the Base Contract or Agreement. The Addendum is limited to the terms and conditions governing the provision of and payment for health services provided to Medicaid members. Attachments are only needed when providers are offering different services or practitioners through the MCOP contract that are identified in the PNM system.

- Attachment A is needed for Group Provider Affiliations, all primary care providers (PCPs) must complete to identify the providers' capacity and service location. Attachment A is also required when a provider has specific practitioner affiliates identified in the PNM who agree to provide services under this plan contract.
- Attachment C is only required when the contract between the MCOP and the provider includes particular specialties rather than all specialties the provider identified in the PNM system.
- The most current Medicaid Addendum is posted on the ODM website here: **https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/managed-care/mc-policy/managed-care-program-appendix/managed-care-program-addenda**.
- The Medicaid Addendum must be completed along with the MCOP provider contract. The ODM Medicaid Addendum supplements the Base Contract or Agreement between the MCOP and provider and runs concurrently with the terms of the Base Contract or Agreement. The Addendum is limited to the terms and conditions governing the provision of and payment for health services provided to

Medicaid members. Attachments are only needed when providers are offering different services or practitioners through the MCOP contract that are identified in the PNM system.
    - Attachment A is needed for all primary care providers (PCPs) to identify the providers' capacity and service location. Attachment A is also required when a provider has specific practitioner affiliates identified in the PNM who agree to provide services under this plan contract.
    - Attachment C is only required when the contract between the MCOP and the provider includes particular specialties rather than all specialties the provider identified in the PNM system.
- The most current Medicaid Addendum is posted on the ODM website here: **https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/managed-care/mc-policy/managed-care-program-appendix/managed-care-program-addenda**.
- The Medicaid Addendum must be completed along with the MCOP provider contract.

Provider Contract Termination

A terminated provider who is actively treating members must continue to treat members until the provider's date of termination. That date is the end of the 180-day period following written notice of termination, or timelines determined by the medical group contract.

Once we receive a provider's notice to terminate a contract, we notify members impacted by the termination to assist them in choosing a new primary care provider (PCP) in our network, if necessary. If the member does not choose another PCP, Anthem will assign the member to a network PCP before the original PCP's disenrollment is effective. Anthem sends a letter to inform affected members of:

- The impending termination of their provider.
- Their right to request continued access to care.
- The Member Services telephone number to make primary medical provider changes.
- Referrals to Utilization Management for continued access to care consideration.

Members under the care of specialists can also submit requests for continued access to care, including continued care after the transition period, by calling Member Services.

Non-Contracted or Unenrolled Providers

As discussed earlier in this section, contracting and enrollment are two separate processes. Both should be completed if you want to provide services to MyCare Ohio enrolled members. Contracting is the process a provider completes with the MCOP whereas enrollment is a process completed with ODM. All providers who are billing for services for MyCare Ohio enrolled members should enroll with ODM through our PNM system. 42 CFR § 438.602 requires ODM to "screen and enroll, and periodically revalidate, all network providers of MCOPs". Federal regulations allow for a 120-day temporary agreement for providers who require more time to enroll in the PNM System. To complete the temporary 120 agreement while you wait for your ODM enrollment to process you must complete the ODM 10295 form. For more information on enrolling with ODM please refer to the beginning of this section of the manual.

Provider education and training resources for PNM, including how to enroll, are located here: PSE Provider Registration Portal - Resources (maximus.com)

Medicaid language

Out-of-state emergency care does not require a prior authorization. Generally, post-stabilization procedures do require prior approval. However, if post-stabilization services are administered to maintain the member's stabilized condition within one hour of the request for authorization, such services will still be covered. Also, if post-stabilization care — administered to maintain, improve, or resolve the member's stabilized condition — requires prior approval and we do not respond within one hour, we will pay the provider for that stabilization

care. We will not pay the provider an amount any greater than we would pay a network provider for those services.

Nonemergency care requires prior authorization. If our network is unable to provide medically needed services in the member service area (or state), we will cover these services adequately and in a timely manner for as long as the services are not available in our network.

Payment to out-of-network providers is made within the same time period required for providers within the network. In addition, we comply with out-of-network provider reimbursement rules as adopted by ODM.

Contracting and enrollment are two separate processes. Both should be completed if you want to provide services to managed care enrolled Medicaid beneficiaries. Contracting is the process of a provider completes with the MCO whereas enrollment is a process completed with the ODM. All providers who are billing for services for Medicaid managed care enrolled beneficiaries should enroll with ODM through our PNM system. 42 CFR § 438.602 requires ODM to "screen and enroll, and periodically revalidate, all network providers of MCOs". Federal regulations allow for a 120-day temporary agreement for providers who require more time to enroll in the PNM System. To complete the temporary 120 agreement while you wait for your ODM enrollment to process you must complete the ODM 10295 form. Provider education and training resources for PNM, including how to enroll, are located here: **PSE Provider Registration Portal - Resources (maximus.com)**.

Please also refer to Section V referring to non-participating providers for more information.

Click to return to Table of Contents

Section VI: Covered services

Covered Services

In addition to providing the full range of required and contracted core benefits and services, Anthem may choose to provide valued-added services (VAS) upon prior approval by the Ohio Department of Medicaid. This provision allows use of medically appropriate services that are not covered under the state-specific benefit package on a case-by-case basis.

Covered services include:

- Inpatient hospital services
- Outpatient hospital services (including those provided by rural health clinics and federally qualified health centers)
- Physician services
- Laboratory and X-ray services
- Immunizations
- Contraceptive services and counseling
- Home health and private duty nursing services
- Podiatry services
- Long-Term Services and Supports (LTSS)
    - For members meeting the following eligibility criteria determined by ODM:
        - Enrolled in MyCare Ohio program at the time of waiver application
        - Determined to meet a nursing facility-based level of care (e.g. intermediate or skilled) per Ohio Administrative Code Rules
        - Require hospitalization or nursing facility services to meet needs in the absence of the waiver
        - Require at least on waiver service per month or
            - Require at least one waiver service per year, and;
            - Conduct a monthly connect with your care coordinator
- Chiropractic services
- Blood glucometers and blood glucose test strips
- Behavioral health services, including treatment for mental health and substance use disorders (see appendix for more information)
- Physical, occupational, developmental, and speech therapy services
- Nurse-midwife, certified family nurse practitioner, and certified pediatric nurse practitioner services
- Durable medical equipment and medical supplies
- Nursing facility services
- Hospice care
- Telehealth
- Dental services, including:
    - For members 21 and older — one cleaning per calendar year
    - For pregnant members — two cleanings per calendar year
    - Dentures, fillings, extractions, crowns, medical and surgical dental services, and root canals (based on medical necessity)
- Vision care services, including:
    - For members 21 to 59 years old — one exam per calendar year and $100 allowance towards purchase and fitting for contacts lens or eyeglasses:
        - No copays
    - For members over 60 years old — one exam and eyeglasses every 12 months
- Transportation services, including:

Click to return to Table of Contents

- Any transportation when the member must travel 30 miles or more from the member's home to receive medically necessary Medicaid-covered care, including pharmacy and dental care.
- Accommodations for special transportation needs of members.
- Value-added transportation services include 30 round trips or 60 one-way trips for trips less than 30 miles from the member's home to access community resources:
  - If the member exhausts the value-added transportation benefit, the health plan works with the member to transition them to their county non-emergency transportation (NET), if possible.

Transportation can include ambulatory sedans, vans, rideshare, bus passes wheelchair assessable vans, mileage reimbursement, or other appropriate modes of transportation.

Anthem does not require referrals before members can see in-network specialty physicians. Prior authorization is necessary before Anthem will pay for services from out-of-network providers, except in cases of emergency.

Anthem offers the following additional benefits — *Subject to change to meet the needs of members*:

Anthem value-added benefits

Anthem also offers extra services and value-added benefits to their members. The benefits outlined below can apply to members who are either dually integrated or Medicaid-only members with Anthem. Please see the list below that explains these extra services.

- Members diagnosed with asthma or COPD can select two relief products from a custom catalog.
- Members diagnosed with diabetes or hypertension can choose one cooking at home item, such as: an air fryer, blender, toaster.
- Members diagnosed with Alzheimer's can receive a digital library card and an eReader.
- Members diagnosed with cardiovascular disease, hypertension, or obesity can select between a wholesale membership, three boxes of produce delivery, or a $150 healthy grocery gift card.
- Receive up to $125 to use for either pest control service or carpet cleaning for members diagnosed with asthma.
- Members referred by care coordination can pick two home safety items from a custom catalog.
- Receive a movie night package which includes a $50 movie gift card and a $50 restaurant gift card for members discharged from a nursing facility, requires care coordination approval.
- Receive a $100 gift card to purchase sensory products for members diagnosed with anxiety, depression, autism, or ADD/ADHD.
- Post-discharge meals — receive up to 14 home-delivered, medically tailored meals to eligible members diagnosed with key, chronic medical conditions, including congestive heart failure (CHF), cancer, HIV/AIDS, end stage renal disease (ESRD),poorly controlled diabetes, or gestational diabetes.
- Receive a $100 gift card to obtain an industry certification.
- SUD Recovery Support - Members can receive access to our Substance Use Disorder Recovery Support program, which is a mobile platform that provides daily motivation/check-in, moderated peer support groups, secure messaging with clinicians and recovery coaches, appointment and medication reminders, and educational content to support ongoing recovery.
- Transportation essentials allows members to select a $100 gift card for a gas card, a rideshare card, or to purchase a bus pass.
  - Medical and community transportation — eligible members will receive transportation services (up to 30 round trips or 60 one-way trips) to provider appointments or to community resources and services within 30 miles of the pick-up location.
- Members receive access to our Emotional well-being program, a web and mobile online community designed to help members cope with emotional and behavioral health issues such depression, anxiety and stress, insomnia, and managing drugs or alcohol.

Click to return to Table of Contents

- Enhanced dental — in addition to the covered benefit, eligible adult members will receive one additional cleaning,
- Enhanced Vision benefit: offers members, ages 21 to 59, with one comprehensive eye exam and a $100 allowance toward eyeglasses or contact lenses.
- Find local resources and community-based programs, benefits, and services with the Community Resource Link.
- Get Connected to Health program offers a smart phone with pre-installed health apps to quickly access care and stay healthy; Care Coordination approval required.
- SDOH Programs
    - SDOH Flex Funds - Flex Funds are a flexible pool of funds that can be used to help pay for expenses that will remove SDOH barriers for MyCare members. This fund can be utilized for a variety of one-time or limited expenses aiming to support members in overcoming obstacles to employment, housing, education, and other social needs.
    - Housing Program - The housing solutions program collaborates with the community to help members with their housing needs and provide comprehensive support services.

Medicare Supplemental Benefits

- Everyday Options Allowance
    - Provides a combined monthly spending allowance of $240 each month to be used on any of the following benefits:
        - Assistive Devices: such as ADA toilet seats, shower stool, hand-held shower heads, reaching devices, temporary wheelchair threshold ramps, and more
        - Over-the-counter: health and wellness products like vitamins, first aid supplies, pain relievers and more
        - Healthy food
        - Utilities
- Personal Emergency Response System (PERS)
- Worldwide Coverage - Provides coverage of care related to a medical emergency and/or urgent care when traveling outside the United States for less than six months. Coverage is limited to $100,000 per year.
- Medicare Community Resource Support - A community resource outreach team available to members to help bridge the gap between member medical benefits and available resources in the community
- Fitness Benefit - This plan covers a fitness benefit through SilverSneakers at participating locations. Member has access to instructors who lead specially designed group exercise classes. At participating locations nationwide, they can take classes plus use exercise equipment and other amenities. Additionally, SilverSneakers FLEX® gives options to get active outside of traditional gyms (like recreation centers, malls and parks). SilverSneakers also connects members to a support network and virtual resources through SilverSneakers Live classes, SilverSneakers On-DemandTM and our mobile app, SilverSneakers GO.
- Meals
    - Post discharge meals, up to 2 meals per day for 21 days
- Dental
    - Provides preventive, diagnostic and comprehensive dental services
- Vision
    - 1 routine eye exam per year
    - Eyeglasses or contact lenses up to $350 per year
- Hearing
    - 1 routine hearing exam per year
    - Member can choose between $300 maximum plan benefit for over-the-counter hearing aids or 1 routine hearing aid fitting evaluation
    - $3,000 maximum plan benefit for prescribed hearing aids per year

Click to return to Table of Contents

- Annual physical exam
- Outpatient Blood Services - Waiver of 3-pint. Including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are also covered beginning with the first pint used.
- Podiatrist Services - Unlimited routine foot care visits each year.
  Removal or cutting of corns or calluses, trimming nails and other hygienic and preventive care in the absence of localized illness, injury, or symptoms involving the feet.

- Nursing Hotline - Plan has 24-hour nurse line, 7 days a
  week, 365 days a year. When calling our nurse line, members can speak directly to a registered nurse who will help answer their health-related questions. The call is toll free and the service is available anytime, including weekends and holidays. Plus, the call is always confidential.

Social drivers of health provider incentive program (SDoHPIP)

The SDoHPIP offers incentives to select Medicaid providers with the following objectives:

- Obtain a baseline of SDoH needs for members
- Increase provider awareness and use of the Community Resource Link (FindHelp) as a resource to refer Anthem members to community organizations that address SDOH needs
- Improve member health outcomes by addressing SDOH needs

The SDoHPIP provides incentives for providers in the SDoHPIP program for the following measures:

- Completing a short member assessment to obtain members' health-related social needs
- Billing appropriate SDoH related diagnosis Z codes on claims
- Referrals to community-based resources through the Community Resource Link (FindHelp) if a member indicates they have one or more SDoH need.
- Successful referral status updates to close the loop on referrals to indicate the members have attended a prior scheduled appointment with a community-based organization

Interested providers can email OhioMedicaidValueBasedPrograms@anthem.com for more information or to enroll in the SDoHPIP.

Behavioral Health Covered Services

Covered behavioral health services include, but are not limited to:

- Inpatient and outpatient behavioral/mental health services
- Substance Use Disorder Residential Treatment
- Outpatient substance use services including intensive outpatient and partial hospital care
- Detoxification services
- Psychiatry services
- Behavioral health and substance use counseling services
- Assertive Community Treatment
- Community psychiatric supportive treatment
- Therapeutic Behavioral Services
- Screening and Brief Intervention and Referral to treatment
- Opioid Treatment Programs
- Mobile Crisis Response Services
- Transcranial Magnetic Stimulation (TMS)

Click to return to Table of Contents

Non-Emergent Transportation Services

Non-emergent transportation is a benefit provided by Anthem to our members through our transportation vendor, MTM Health. This benefit covers routine, non-emergency one-way trips (60-mile limit per one-way trip) to locations within the local service area when obtaining plan-approved health-related services. Trips may be covered for getting to and from plan-approved medical related visits and visits to a pharmacy to pick up prescriptions. Members can use this benefit for one-way trips and they can schedule a round trip by using two one-way trips (this includes special vehicle transportation for Anthem members in wheelchairs). Routine rides should be scheduled at least 48 hours in advance of the transportation needs.

Members should call **800-282-9720** (Monday to Friday, 8 a.m. to 7 p.m. ET) to schedule rides or call Member Services at: **833-727-2169 (TTY: 711)** (Monday to Friday, 8 a.m. to 8 p.m. ET). Members can also request a ride on their website: **https://mtm.mtmlink.net**.

Emergency Transportation

Anthem covers emergency transportation services without prior authorization when a member's condition is life-threatening and requires use of special equipment, life support systems and close monitoring by trained attendants while en route to the nearest appropriate facility. Emergency transportation is also available for facility-to-facility transfers when the required emergency treatment is not available at the first facility.

Transportation Services for Members Enrolled in OhioRISE

Anthem must arrange and provide transportation for members who are enrolled with the OhioRISE plan in a manner that ensures that children, youth, and their families served by the OhioRISE plan do not face transportation barriers to receive services regardless of Medicaid payer. Anthem is responsible for arranging transportation in cases where transportation of families, caregivers, and sibling(s) (other minor residents of the home) is needed to facilitate the treatment needs of the member, even when the member is not being transported.

Telehealth

Telehealth enables a provider who is located at a distant site to render the service remotely to a member located at an originating site using a combination of interactive video, audio, and externally acquired images through a networking environment. To promote telehealth expansion, Anthem offers a telehealth HOS secure platform free of charge for Anthem contracted providers. For more information about this service, please contact your Provider Experience consultant or email ohiomedicaidprovider@anthem.com.

Telehealth means a practice of healthcare delivery, diagnosis, consultation, treatment, or transfer of medically relevant data by means of audio, video, or data communications that are used either during a patient visit or a consultation or are used to transfer medically relevant data about a patient. Telehealth does not include communications delivered solely by audio-only telephone, facsimile machine, or electronic mail unless the department specifies otherwise by rule.

Telehealth offers multiple benefits to providers and members:

- The member can continue to be cared for by their local provider.
- The member does not need to travel long distances to receive specialist care.
- The PCP receives all records and test results from the encounter.
- The PCP consults with the specialist participating in the telehealth encounter to design any necessary course of treatment.

Please refer to ODM's **telehealth billing guidelines** for specific details on place of service, modifiers, and CPT billing combinations.

Click to return to Table of Contents

Telehealth can also be used for nonclinical consults such as community services, continuing medical education, and other provider training sessions.

All laws regarding the privacy, security and confidentiality of healthcare information and a patient's rights to their medical information and personal information shall apply to telehealth interactions. This section shall not be construed to alter the scope of practice of any healthcare provider or authorize the delivery of healthcare services in a setting, or in a manner, not otherwise authorized by law. Telehealth services are used to support healthcare when the provider and patient are physically separated. Typically, the patient communicates with the provider via interactive means (in other words, live audio/video feed). Participating providers and facilities shall be solely responsible for ensuring the security and privacy of their interactive audio/video platform. Such platform must at a minimum include technical, administrative, and physical safeguards to ensure that all information pertaining to covered members is protected in accordance with applicable law utilizing controls equivalent to those necessary for compliance with the *Health Insurance Portability and Accountability Act* (*HIPAA*).

Service Standards

Access — Anthem pays for telehealth care services delivered by care providers contracted with the health plan. The telehealth providers must confirm member eligibility every time members access virtual visits, similar to in-person visits.

Staffing credentials — All professional staff are certified or licensed in their specialty or have a level of certification, licensure, education, and/or experience in accordance with state and federal laws.

Staff orientation and ongoing training — The telehealth providers must comply with all applicable state, federal, and regulatory requirements relating to their obligations under contract with Anthem. Telehealth providers must participate in initial and ongoing training programs including policies and procedures.

Service response time — The telehealth provider will comply with the response time requirements outlined in their contract.

Informed consent — Appropriate consent from the member must be obtained by the provider prior to delivering services. Providers should always give the member the choice between a traditional clinical encounter versus a telemedicine visit. Appropriate consent from the member must be obtained by the originating site and documentation maintained at both the distant and originating sites.

Compliance and security — The telehealth platform should be *HIPAA*-compliant and meets state, federal, and 508 compliance requirements. The telehealth providers will conduct all member virtual visits via interactive audio and/or video telecommunications systems using a secure technology platform and will maintain member records in a secure medium, which meets state and federal law requirements for security and confidentiality of electronic patient information.

Certification — Anthem strongly encourages providers to obtain CHIQ, URAC, or ATA accreditation.

Continuous quality improvement (CQI) — The telehealth providers must have a documented CQI program for identifying through data opportunities for real, time measured improvement in areas of core competencies. There must be demonstrated ties between CQI findings and staff orientation, training and policies, and procedures.

Member complaints — The telehealth providers are not delegated for complaint resolution but will log, by category and type, member complaints and should refer member complaints to National Call Center.

Click to return to Table of Contents

Regulatory assessment results — Anthem reserves the right to request access to any applicable regulatory audit results.

Utilization — The telehealth provider will comply with the reporting requirements outlined in their contract.

Electronic billing/encounter coding — The telehealth provider will submit virtual visit encounters or claims with proper coding as part of its existing encounter submission process.

Eligibility verification — The telehealth provider will use existing eligibility validation methods to confirm virtual visit benefits.

Case communication — The telehealth provider will support patient records management for virtual visits using existing EMR systems and standard forms. Its EMR records should contain required medical information including referrals and authorizations.

Professional environment — The telehealth provider will help ensure that, when conducting virtual visits with members, the rendering care provider is in a professional and private location. The telehealth provider (rendering care providers) will not conduct member virtual visits in vehicles or public areas.

Medical director — The telehealth provider will employ or engage a licensed care provider as medical director. The medical director is responsible for clinical direction.

Emergency and Related Professional Services

Emergency services, as defined by state and local law, the Provider Agreement, and our member handbook, are reimbursed in accordance with the Anthem Provider Agreement.

Emergency services do not require prior authorization.

An emergency is any condition manifesting itself by acute symptoms of sufficient severity such that a layperson possessing an average knowledge of health and medicine could reasonably expect that the absence of immediate medical care could:

- Place the member's health in serious jeopardy or, with respect to a pregnant woman, the health of the woman.
- Cause serious impairment to bodily functions.
- Cause serious dysfunction to any bodily organ or part.

Covered emergency services include:

- Inpatient services, outpatient services, or medical transportation services that are provided by a qualified provider and are needed to evaluate, treat, or stabilize an emergency medical condition.
- Providers of emergency services also include physicians or other healthcare professionals or healthcare facilities not under employment or under contractual arrangement with Anthem.

All members should be referred back to their PCP for follow-up care. Unless clinically required, follow-up care should never occur in a hospital emergency room.

Dental Services

Routine dental care is covered for qualifying members by Anthem through Liberty Dental Plan. **For claim submission and prior authorization, providers should submit directly to Liberty Dental Plan.** Please refer to the value-added benefits section for more information on dental value-added benefits.

Click to return to Table of Contents

Vision Services

Anthem contracts with EyeMed to provide covered routine vision services. Anthem covers the following services when performed by a EyeMed contracted provider:

- Routine vision services
- Eyeglasses

To arrange for vision services, call EyeMed: **877-497-4626**.

Please refer to the value-added benefits section for more information on vision value-added benefits.

Claims should be submitted directly to EyeMed.

Noncovered Services

Anthem will not pay for services or supplies received that are not covered by Medicaid:

- Services that are experimental in nature and are not performed in accordance with standards of medical practice
- Services that are related to forensic studies
- Autopsy services
- Services for the treatment of infertility
- Abortion services that do not meet the criteria for coverage in accordance with Ohio Administrative Code rule *5160-17-01*
- Services pertaining to a pregnancy that is a result of a contract for surrogacy services
- Assisted suicide and other measures taken actively with the specific intent of causing or hastening death; and
- Services that do not meet the criteria for coverage set forth in any other rule in Ohio Administrative Code Agency *5160*.

New Baby, New Life℠

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

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

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

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

As part of the New Baby, New Life program, perinatal members have access to a digital maternity program. The digital program provides pregnant and postpartum members with proactive, culturally-appropriate education

via a smartphone app. Once members are identified as being pregnant, they will receive an invitation to access this program by downloading the app. After the app is installed and the member registers, they are asked to complete a pregnancy screener. The answers provided in the screener allows Anthem to assess their pregnancy risk.

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

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

For more information about the New Baby, New Life program or the digital maternity tools, reach out to your OB Practice Consultant or Provider Services at **833-727-2170,** Monday through Friday, 8 a.m. to 8 p.m. ET, or refer to our website at **https://www.anthem.com/oh/provider/state-federal**.

ODM's NurtureOhio Portal

Anthem encourages providers to complete the state's *Pregnancy Risk Assessment* form (*PRAF*), which can be completed via **NurtureOhio** or via paper faxed form. For detailed instructions, please visit the state's website: **https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/special-programs-and-initiatives/praf/praf**

The **PRAF 2.0 Provider User Manual** can assist you in setting up access for your staff and assigning the prenatal visit role needed to access the PRAF 2.0. The user manual provides step by step instructions for completing the PRAF 2.0.

We also encourage providers to complete the Maternity form in Availity Essentials:

- Perform an Eligibility and Benefits (E&B) request on the desired member.
- Choose one of the following benefit service types: maternity, obstetrical, gynecological, or obstetrical/gynecological.
- Before the benefit results screen, you will be asked if the member is pregnant. Choose **Yes**, if applicable. If you indicate **Yes**, provide the estimated due date, if it is known, or leave it blank if the due date is unknown. You may update the estimated due date as soon as it is known.
- After submitting your answer, the E&B will display. If the member was identified as pregnant, a Maternity form will be generated. Once generated, you may access the form in the Maternity work queue.
- After delivery, go into the Maternity Work Queue and update details, complete the questions in the form, and SUBMIT the form for all PENDING status forms.
- *Note*: this does not replace the need to submit a PRAF via NurtureOhio.

Anthem requires notification of delivery following birth. Please send birth clinical data to the PNM portal.

Condition Care

Our state-sponsored Condition Care programs are based on a system of coordinated case management interventions and communications designed to assist physicians and others in managing members with chronic conditions.

Our mission
The mission of the Condition Care program is to improve the health and quality of life for Anthem members served by encouraging member self-care efforts, coordinating healthcare education, and providing interventions along the continuum of care.

Services include:
- A holistic, member-centric approach to Condition Care, 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 disease to meet the changing healthcare needs of our member population.
- Weight management and smoking cessation education.

Who is eligible?
Members diagnosed with one or more of the conditions listed below are eligible for Condition Care services:
- Asthma
- Bipolar disorder
- Chronic obstructive pulmonary disorder
- Congestive heart failure
- Coronary artery disease
- Diabetes
- HIV/AIDS
- Hypertension
- Major depressive disorder
- Schizophrenia
- Substance use disorder

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 risk-stratified based on the severity of their condition care. They are provided with continuous education on self-management concepts, which include primary prevention, coaching related to healthy behaviors and compliance/monitoring as well as case/care coordination for high-risk members. Program evaluation, outcome measurement and process improvement are built into all the programs. Providers are given telephonic and/or written updates regarding patient status and progress.

To refer a member to Condition Care, fill out our *Condition Care Referral Form* at **https://www.anthem.com/oh/provider/state-federal** > and email the completed form to Condition-Care-Provider-Referrals@anthem.com.

Program features:
- Program content is based on evidence-based clinical practice guidelines
- Collaborative practice models that include the physician and support providers in treatment planning
- Continuous self-management education
- Ongoing communication with providers regarding patient status
- Our Condition Care programs are National Committee for Quality Assurance (NCQA)-accredited and incorporate outreach, education, care coordination and follow-up to improve treatment compliance and enhance self-care.

Click to return to Table of Contents

Anthem Condition Care *Clinical Practice Guidelines* are located at **https://www.anthem.com/oh/provider/state-federal**. A copy of the guidelines can be printed from the website, or you can contact Provider Services at **833-727-2170,** Monday through Friday, 8 a.m. to 8 p.m. ET to receive a copy.

Condition Care provider rights and responsibilities
The provider has the right to:

- Have information about Anthem, including provided programs and services, our staff, and our staff's qualifications and any contractual relationships.
- Decline to participate in or work with the Anthem programs and services for their patients, depending on contractual requirements.
- Be informed of how Anthem coordinates our interventions with 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 to make decisions interactively with patients regarding their healthcare.
- Receive courteous and respectful treatment from Anthem staff.
- Communicate complaints regarding Condition Care as outlined in the Anthem provider complaint and grievance procedure.

Condition Care Contact Information
Additional information about Condition Care can be obtained by visiting **https://www.anthem.com/oh/provider/state-federal**. Members can also obtain information by calling **833-727-2169, TTY 711**.

24/7 NurseLine

We recognize that questions about healthcare prevention and management do not always come up during office hours. The 24/7 NurseLine, a phone line staffed by registered nurses, provides a powerful provider support system and is a component of after-hours care. The 24/7 NurseLine allows members to closely monitor and manage their own health by giving members the ability to ask questions whenever the need arises. The 24/7 NurseLine is available 24 hours a day, 7 days a week.

- Phone: **855-658-9249**
- TTY: **711**

Members may contact the 24/7 NurseLine for:

- Self-care information, including assistance with symptoms, medications and side-effects, and reliable self-care home treatments.
- Access to specialized nurses trained to discuss health issues specific to our teenage members.
- Information on more than 300 healthcare topics through the 24/7 NurseLine audio tape library.

Nurses on 24/7 NurseLine have access to telephone interpreter services for callers who do not speak English. All calls are confidential.

Grievance, Appeal, and State Hearing Procedure

Pre-service utilization management appeals

When Anthem denies an authorization request as not medically necessary, the member and any person or entity acting on behalf of the member, with members written consent on file, will receive a *Notice of Action* denial letter.

State of Ohio defines an appeal as the members request for review of an adverse benefit determination.

Providers and members have the right to file appeals through a formal process.
Providers must have written consent from the member to file an appeal on the member's behalf. Anthem will begin processing the appeal upon receipt of the written consent.

The member or person acting on behalf of the member can file an appeal orally or in writing within 60 days of the date of the Notice of Action denial letter.

Appeals should be submitted utilizing the ODM standardized appeal form (*Ohio Medicaid Managed Care Entity Member Appeal Form*).

Ohio standardized appeal form will be utilized to submit an appeal. Providers on behalf of members can submit an appeal utilizing Interactive Care Reviewer via Availity Essentials, or by fax **866-587-3316**.

Members can also submit appeals in the following methods:
Fax: Directly to the Appeals Department at fax **888-458-1406**
Can also mail the form to:
Anthem MyCare:

Medicare Complaints, Appeals & Grievances
Mailstop: OH0205-A537
4361 Irwin Simpson Rd
Mason, OH 45040

Anthem MyCare Medicaid only:

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

Should providers have any questions regarding the appeal process or how to file an appeal, please contact Provider Services at **833-727-2170**, Monday through Friday, 8 a.m. to 8 p.m. ET.

Alternatively, if an authorization is denied prior to the service being rendered to the member, the provider also has the option to file an appeal directly with Anthem — not requiring the member consent.

Provider appeals can be submitted in the following ways:
Electronically: Using Availity Essentials at Availity.com
Fax: Directly to the Appeals Department at **888-458-1406**
Appeals must be submitted within 60 calendar days from initial determination. Anthem will send written acknowledgment of the appeal to provider within three business days of receipt.

Click to return to Table of Contents

- Anthem will issue a decision within 10 calendar days for non-urgent services and 48 hours for urgent care services.
- Appeals submitted by providers without the consent of the member are not eligible for State Fair Hearings however providers may request an additional External Medical review (see external medical review process)

Appeal Timelines

Anthem will send written acknowledgment of receipt of the appeals to member and their representatives within three business days of receipt of the appeal.

Standard appeals must be submitted within 60 calendar days from initial determination. All standard appeals will be reviewed and resolved within 15 calendar days of the receipt of the appeal unless an extension is approved.

Expedited appeals will be reviewed and resolved within 72 hours from receipt of the appeal unless extension of timeframe is approved:

- Anthem will provide prompt oral notification to the member or representative of the decision to expedite or not expedite the appeal resolution
- If Anthem denies a request to expedite an appeal the appeal will be transferred to standard timeframe of 15 calendar days

Appeal Decisions

Appeals decided in favor of member:

- Written notice of the appeal's resolution to the member and authorized representative
- The notice will include the resolution decision and the date of resolution, at a minimum
- Anthem will update the authorization no later than 72 hours from the appeal resolution

Appeal resolutions not resolved wholly in the member's favor

Written notification of the appeal's resolution to the member and authorized representative written resolution notice will also include:

- The right to request a state hearing and how to request state hearing with attached ODM forms.
- The right to continue to receive benefits pending a state hearing and how to request to request continuation of benefits.

Member Grievances

Anthem member may file a grievance with orally or in writing at any time. An authorized representative must have the member's written consent to file a grievance on the member's behalf.
Members can file a grievance by printing the form and send it via:

- Fax: **888-458-1406**
- Send the appropriate form to:

Anthem MyCare:

Medicare Complaints, Appeals & Grievances
Mailstop: OH0205-A537
4361 Irwin Simpson Rd
Mason, OH 45040

Anthem MyCare Medicaid only:

Medical Appeals

Click to return to Table of Contents

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

- Email: ohioga@anthem.com; or
- Call Member Services at 833-727-2169 (TTY 711) Monday to Friday from 8 a.m. to 8 pm. Eastern time.

Anthem reviews and resolves all grievances as expeditiously as the member's health condition requires:

- Within two business days of receipt if the grievance is regarding access to services
- Within thirty calendar days of receipt for non claims-related grievances
- Within sixty calendar days of receipt for claims-related grievances.

At a minimum, Anthem will provide oral notification to the member of a grievance resolution. If Anthem is unable to speak directly with the member, or the resolution includes information that must be confirmed in writing, the resolution shall be provided in writing simultaneously with the Anthem's resolution.

State Fair Hearings

If a resolution to an appeal is to uphold the denial of a request for the authorization of a service, in whole or in part, due to Anthem's denial of payment for that service, Anthem will notify the member of their right to request a state hearing and issue the *Notice of Denial of Medical Services By Your Managed Care Entity* (ODM 04043).

If an appeal resolution upholds the decision to reduce, suspend, or terminate services prior to the member receiving the services as previously authorized by Anthem, the Anthem will issue the *Notice of Reduction, Suspension or Termination of Medical Services By Your Managed Care Entity* (ODM 04066).

If a member or their representative does not agree with the appeal decision, they can request a State Fair Hearing. The request for a state fair hearing is made through the State of Ohio within 90 calendar days from the date at the top of the appeal resolution letter as outlined below.

Members must exhaust Anthem appeals process before requesting a state hearing:

- If Anthem fails to adhere to notice and timing requirements as set forth in OAC rule 5160-26-08.4, the member is deemed to have exhausted the appeal process and may request a state hearing.

State Fair Hearing request can be submitted to the State of Ohio in the following ways:

- Online – Go to **https://hearings.jfs.ohio.gov/SHARE**
- Email – Send an email to bsh@jfs.ohio.gov**.** In the subject, put "State Hearing Request". In the message, make sure to put your name, case number, address, phone number where you can be reached, date you received this notice, and why you want a hearing.
- Phone – Call the ODJFS Consumer Access Line at **866-635-3748**. Follow the instructions for State Hearings and mention this notice.
- Fax – Complete, sign, and fax both pages of this notice to State Hearings at **614-728-9574**.
- Mail – Complete, sign and mail both pages of this notice to State Hearings, P.O. Box 182825, Columbus, Ohio 43218- 2825.
- By Contacting their caseworker

Continuation of Benefits

Anthem shall continue a member's benefits during the appeals and State Fair Hearing when all the following conditions are met:

a. The member requests an appeal within 15 days of the issuance of the *Notice of Action.*
b. The appeal involves the termination, suspension, or reduction of services prior to the member receiving the previously authorized services.
c. The services were ordered by an authorized provider.

Click to return to Table of Contents

d. The authorization period has not expired

If the final resolution of the appeal or state hearing upholds Anthem's original adverse benefit determination, the member may be responsible for payment, and Anthem may recover the cost of the services furnished to the member while the appeal and/or state hearing was pending.

Anthem ensures that its members have appropriate assistance in a culturally and linguistically appropriate manner in the filing process including a toll-free number through a TTY, oral, written, and verbal provision of the language assistance for members to discuss UM issues that is available upon request.

Provider Complaints

The Ohio Department of Medicaid (ODM) maintains a managed care organization (MCO) complaint form. It can be used by any provider who has first attempted to work directly with Anthem but believes they have been unsuccessful in getting an appropriate response. Before submitting a complaint about a claim, providers should check the plan's Claims Payment Systemic Errors (CPSE) report (**https://www.anthem.com/oh/provider/state-federal**) for the issue in question, estimated resolution date, and claim reprocessing date.

Anthem will receive these complaints directly, in real time, from ODM and have 15 business days to respond to the provider with a resolution. Providers are encouraged to utilize the appeals, grievance, or arbitration processes as outlined in their individual contract with the MCO.

The *Provider Complaint* form is located on the ODM website. (**https://providercomplaints.ohiomh.com/ComplaintForm.aspx?forceredirect=true**) or on the Anthem Provider website.

Section VII: Utilization Management

Services Requiring Prior Authorization

To determine prior authorization requirements, use the lookup tool on the Prior authorization page of the provider website at **https://www.anthem.com/oh/provider/state-federal.**

Please note: Emergency hospital admissions and observation admissions do not require prior authorization. However, notification is required within 48 hours or the next business day if member is going to be inpatient via Availity Essentials at **Availity.com** or by fax.

All utilization management requests should be submitted via Availity Essentials at **Availity.com** or by fax.

Overview

Anthem's Utilization Management program is a cooperative effort with providers to promote, provide and document the appropriate use of healthcare resources. Our goal is to provide the right care, to the right member, at the right time, in the appropriate setting.

The decision-making process is based on health plan and state guidelines as well as National Committee for Quality Assurance (NCQA) guidelines and reflects the most up-to-date Medical Management standards. Healthcare authorizations are based on the following:

- Benefit coverage
- Community standards of care
- Established Ohio Department of Medicaid (ODM) developed criteria or in the absence of ODM-developed criteria MCG, Anthem *Medical Policies* & Anthem *Clinical UM Guidelines*/CarelonRx, Inc. criteria, as applicable.
    - Anthem's clinical reviewers use the following criteria when making a medical necessity determination for Medicaid:
        1. Federal Medicaid Mandates
        2. State Manuals/State Contracts/State Policy/ASAM
        3. MCG®
        4. Anthem *Medical Policies*
        5. Carelon Medical Benefits Management, Inc. *Clinical Guidelines*
        6. CarelonRx *Clinical Criteria*
        7. Anthem *Clinical UM Guidelines*

The decision-making criteria used by the Utilization Management department are evidence-based and consensus driven. We update criteria periodically as standards of practice and technology change. We involve practicing physicians in these updates and notify providers of changes through fax communications (such as provider bulletins) and other web postings and mailings. Based on sound clinical evidence, the Utilization Management department provides the following service reviews:

- Prior authorizations
- Concurrent/continued stay reviews
- Retrospective reviews — If member has been discharged, please submit your supporting clinical documentation with your claim submission.

Decisions affecting coverage or payment for services are made in a fair, consistent, and timely manner. The decision-making process incorporates nationally recognized standards of care and practice from sources including:

- American College of Cardiology
- American College of Obstetricians and Gynecologists

- American Academy of Pediatrics
- American Academy of Orthopedic Surgeons
- Cumulative professional expertise and experience

Shared decision-making (SDM) aids provide information about treatment options and outcomes. SDM aids are designed to complement practitioner counselling, not replace it. SDM aids facilitate member and practitioner discussion on treatment decisions.

Utilization management-related resources and forms and criteria are available on our website at **https://www.anthem.com/oh/provider/state-federal**. Our online *Clinical UM Guidelines* are also available upon request at Provider Services **833-727-2170** Monday through Friday, 8 a.m. to 8 p.m. ET or by e-mailing us at ohiomedicaidprovider@anthem.com.

After a case has been reviewed, notification of the decision will be sent to the provider via Availity Essentials or fax coversheet and written notification will be sent if the request has been denied.

Please note: Decisions are based on appropriateness of care and service and existence of coverage. We do not reward practitioners and other individuals conducting utilization reviews for issuing denials of coverage or care. There are no financial incentives for Utilization Management decision-makers that encourage decisions resulting in under-utilization.

Prior Authorization Submission Process

You may contact us with prior authorization questions regarding healthcare services including:

- Routine, non-urgent care reviews.
- Urgent or expedited pre-service reviews.
- Concurrent or continued stay reviews.

To request prior authorization or report a medical admission, your request must be submitted through Availity Essentials at **Availity.com** or by fax.

- Member name and ID number
- Diagnosis with the ICD code
- Procedure with the CPT code
- Date of injury or hospital admission and third-party liability information, if applicable
- Facility name, if applicable
- PCP
- Specialist or attending physician name
- Clinical justification for the request
- Level of care
- Lab, radiology, and pathology test results
- Medications
- Treatment plan, including time frames
- Prognosis
- Psychosocial status
- Exceptional or special needs issues
- Ability to perform activities of daily living
- Discharge plans

All inpatient requests, post-acute requests, and selected outpatient procedures require prior authorization. For the latest information about which services require prior authorization, go to **https://www.anthem.com/oh/provider/state-federal**.

Pre-Service Review Time Frames

For routine, non-urgent requests, the UM team will provide notice to the provider and member as expeditiously as the member's health condition requires but no later than 10 calendar days following receipt of the request for service. Requests that do not meet medical policy guidelines are sent to the physician advisor or medical director for further review. For any questions, please review Sections *OAC 5160-26.03.1* and *ORC 5160.34*.

Urgent Requests

For urgent requests, the UM team will provide notice of the authorization decision as expeditiously as the member's health condition requires but no later than 48 hours after receipt of the request for service. Generally speaking, the provider is responsible for contacting us to request pre-service review via Availity Essentials at **Availity.com** or by fax for both professional and institutional services. However, the hospital or ancillary provider should also contact Anthem to verify pre-service review status for all non-urgent care before rendering services.

If a request is determined not to be of an urgent request by the UM department, the request will be changed to an elective request and the provider will be notified.

Timeliness of Utilization Management Decisions:

- For non-urgent pre-service requests: 10 calendar days
- For urgent pre-service requests: 48 hours

Anthem's Utilization Management staff has appropriately qualified UM review staff who are available for inbound and outbound calls by the telephone number identified below from 8 a.m. to 5 p.m. ET, Monday through Friday, (except for the major holidays and two optional closure days) to render UM decisions. After normal business hours, UM review staff is available by telephone 24/7 for inbound communication to respond to authorization requests for inpatient admissions. When initiating or returning calls regarding UM issues, all Anthem's staff members identify themselves by providing their name, job title, and organization.

Utilization management fax numbers

MyCare
Inpatient authorization fax:

- **877-423-9972** (physical health)-concurrent reviews for inpatient and admission requests for SNF/LTAC/Acute Rehab/NF
- **866-959-1537** elective admissions

Outpatient authorization fax:

- **866-959-1537** elective admissions and outpatient services including durable medical equipment and home health care
- **800-563-5581** medical injectables
- **877-643-0672** (Physical Health) home health care, physical therapy, occupational therapy, speech therapy, private duty nursing, durable medical equipment, chiropractic and acupuncture

Medicaid (if Medicare benefits have been exhausted)

Click to return to Table of Contents

Inpatient Authorization Fax:

- **877-643-0671** (physical health)-concurrent reviews for inpatient and admission requests for SNF/LTAC/Acute Rehab/NF
- **800-964-3627** elective admissions

Outpatient authorization fax:

- **877-643-0672** (Physical Health)-home health care, physical therapy, occupational therapy, speech therapy, private duty nursing, durable medical equipment, chiropractic and acupuncture
- **800-563-5581** medical injectables
- **800-964-3627** elective admissions and outpatient surgeries

Emergency Medical Services

Anthem does not require prior authorization for treatment of emergency medical conditions. In the event of an emergency, members may access emergency services 24 hours a day, 7 days a week. If the emergency room visit results in the member's admission to the hospital, providers must contact Anthem within 48 hours. Members may remain in an observation status for 48 hours.

Emergency stabilization and post-stabilization

The emergency department's treating provider determines the services needed to stabilize the member's emergency medical condition.

The emergency department should send a copy of the emergency room record to the PCP's office within 24 hours. The PCP should:

- Review and file the chart in the member's permanent medical record.
- Contact the member.
- Schedule a follow-up office visit or a specialist referral, if appropriate.

Reconsideration

A reconsideration process is available to providers following an adverse determination. During the reconsideration process, providers will have an opportunity to submit additional clinical information to substantiate medical necessity for a previously denied pre-service or concurrent inpatient stay. To submit a reconsideration, please submit new clinical information and place "reconsideration" on the cover sheet.

Timeframes for Reconsideration of Denied Services:

- Reconsideration: 30 calendar days after date of Utilization Management denial
- Peer-to-peer: 7 calendar days after the date of Utilization Management denial
- Appeals: Within 60 calendar days from the date of Utilization Management denial

Please note, a reconsideration is not an appeal and does not limit subsequent appeal rights.

Peer-to-Peer Consultations

Providers may request a peer-to-peer consultation when the MCOP denies a prior authorization request. The peer-to-peer consultations will be conducted amongst health care professionals who have clinical expertise in treating the member's condition, with the equivalent or higher credentials as the requesting/ordering provider. The peer-to-peer consultation must clearly identify what documentation the provider must provide to obtain approval of the specific item, procedure, or service; or a more appropriate course of action based upon accepted clinical guidelines.

Utilization Management Provider Appeals

Providers may request a provider appeal if the MCOP denies a prior authorization request in accordance with ORC 5160.34. The provider appeal is separate from the peer-to-peer or member appeal processes. Provider appeals will be responded to within forty-eight hours for urgent care services and within ten calendar days for all other matters.

External Medical Review

The review process conducted by an independent, external medical review (EMR) entity that is initiated by a provider who disagrees with a MCOP's decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity. MCOPs are required to notify providers of their option to request an EMR as part of any medical necessity denial.

Currently, the EMR will be conducted by Permedion. This vendor has a contract with ODM to complete the third-party medical review.

To request an EMR, providers must first appeal the decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity using the MCOP's internal provider appeal or claim dispute resolution process. Failure to exhaust the MCOP's internal appeals or claim dispute resolution process will result in the provider's inability to request an EMR.

An EMR can be requested by a provider as a result of:

- An MCOP's service authorization denial, limitation, reduction, suspension, or termination (includes pre-service, concurrent, or retrospective authorization requests) based on medical necessity; or
- An MCOP's claim payment denial, limitation, reduction, suspension, or termination based on medical necessity.

Denials, limitations, reductions, suspensions, or terminations based on lack of medical necessity include, but are not limited to decisions made by the plan where:

- Clinical documentation or medical record review is required in making the decision to deny (includes preservice, concurrent, and retrospective reviews).
- Clinical judgement or medical decision making (i.e., referred to a licensed practitioner for review) is involved.
- A clinical standard or medical necessity requirement (e.g., InterQual®, MCG®, ASAM, or OAC rule 5160-1- 01 and/or the MCOP's clinical coverage or utilization management policy or policies) is not met.

Requesting an External Medical Review

The request for an EMR must be submitted to Permedion within 30 calendar days of the written notification that the internal appeals or provider claim dispute process has been exhausted.

Providers must complete the "Ohio Medicaid MCE External Review Request" form located at www.hmspermedion.com (select Contract Information and Ohio Medicaid) and submit to Permedion together with the required supporting documentation including:

- Copies of all adverse decision letters from MCOP (initial and appeal)
- All medical records, statements (or letters) from treating health care providers, or other information that provider wants considered in reviewing case.
- Providers may submit new or other relevant documentation as part of the EMR request.

Providers must upload the request form and all supporting documentation to Permedion's provider portal located at https://ecenter.hmsy.com/ (new users will send their documentation through secured email at IMR@gainwelltechnologies.com to establish portal access).

Click to return to Table of Contents

If the MCOP determines the provider's EMR request is not eligible for an EMR and the provider disagrees, ODM or its designee will determine if an EMR is appropriate.

The EMR process does not interfere with the provider's right to request a peer-to-peer review, or a member's right to request an appeal or state hearing, or the timeliness of appeal and/or state hearing resolutions.

Once the provider has submitted the EMR request, they do not need to take further action.

Completing the External Medical Review

After the EMR request has been submitted, Permedion will share any documentation from the provider with the MCOP. Following its review of this information, the MCOP may reverse its denial, in part or in whole. If the MCOP reverses any part of its decision the provider will receive a written decision within one business day for expedited prior authorization requests and 5 business days for standard prior authorization requests and notify the EMR entity. If the MCOP decides to reverse its decision in part, the remaining will continue as an EMR.

Permedion has 30 calendar days for a standard request and three business days for an expedited request to perform its review and issue a decision.

- If the decision reverses the MCOP's coverage decision in part or as a whole, that decision is final and binding on the MCOP.
- If the decision agrees with the MCOP's decision to deny, limit, reduce, suspend, or terminate a service, that decision is final.

For reversed service authorization decisions, the MCOP must authorize the services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from when the MCOP receives the EMR decision.

For reversed decisions associated solely with provider payment (i.e., the service was already provided to the member), the MCOP must pay for the disputed services within the timeframes established for claims payment in Appendix L of the MyCare Ohio Provider Agreement.

For more information about the EMR, please contact Permedion at **1-800-473-0802** and select Option 2.

Carelon Medical Benefits Management

Carelon Medical Benefits Management provides clinical solutions that drive appropriate, safe, and affordable care. Serving more than 50 million Members across 50 states, D.C. and U.S. territories, Carelon Medical Benefits Management promotes optimal care using evidence-based clinical guidelines and real-time decision support for both Providers and Facilities and their patients. The Carelon Medical Benefits Management platform delivers significant cost-of-care savings across an expanding set of clinical domains. The programs that Anthem Blue Cross and Blue Shield Ohio Medicaid elected to implement (for dates of service on or after December 1, 2024) are radiology, cardiology, genetic testing, sleep medicine and musculoskeletal care.

Visit Carelon Medical Benefits Management's program **microsite** to find program information, resources, clinical guidelines, interactive tutorials, worksheets and checklists, FAQs, and access to the provider portal.

Pre-certification Requests to Carelon Medical Benefits Management

Ordering and servicing Providers and Facilities may submit Pre-certification requests to Carelon Medical Benefits Management in one of the following ways:

Click to return to Table of Contents

Access the Carelon Medical Benefits Management provider portal at **providerportal.com** or through Availity at **Availity.com**. Online access is available 24/7 to process orders in real-time and is the fastest and most convenient way to request authorization.

Call Carelon Medical Benefits Management toll-free at **(833)-500-6966**, Monday through Friday between 8 a.m. to 8 p.m. ET.

OptiNet Registration

The OptiNet Registration is an important tool that assists ordering Providers and Facilities in real-time decision support information to enable ordering Providers and Facilities to choose high-quality, low-cost imaging and genetic counseling Providers and Facilities for their patients. Servicing Providers and Facilities need to complete the OptiNet Registration online.

To access the OptiNet Registration:

- Access the provider portal directly at **providerportal.com**
    - Once logged into Carelon Medical Benefits Management, from the My Homepage screen, choose Access OptiNet Registration.
- Select the Registration Type and choose the Access OptiNet Registration button.
- Complete the requested information.

The registration does not need to be completed in one sitting. Data can be saved throughout the registration process. Once the registration has been submitted, a score card will be produced for Radiation Solution Facilities. Genetics Testing Facilities will not have a score card. The score for the Facility will be presented to the ordering Provider or Facility when the particular Facility is selected as a place of service which drives Ordering Provider Decision Support.

For technical questions, contact Web Support at 800-252-2021. For specific OptiNet customer services requests, contact 877-202-6543. For any other questions, contact Anthem Provider Services.

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

Click to return to Table of Contents

Section VIII: Claims Information

Overview

Having a fast and accurate system for processing claims allows providers to manage their practices and our members' care more efficiently. With that in mind, we have made claims processing as streamlined as possible. Share the following guidelines with your staff, billing service and electronic data processing agents:

- Submit clean claims, making sure the right information is on the right form.
- Submit claims as soon as possible after providing service.
- Submit claims within the contracted filing time limit.

Providers can check claim status through Availity Essentials at **Availity.com** by selecting **Claims & Payments,** then **Claim Status**. Providers must be registered with Availity Essentials to access this secure website. Once signed up, you can log in to a single account and perform numerous administrative tasks for patients covered by us or other selected payers. Providers may also access Availity Essentials from our website at **https://www.anthem.com/oh/provider/state-federal** by selecting **Login** or **Register**. Detailed information on accessing Availity Essentials is available at **Availity.com** or on our website.

In this chapter, we also provide a detailed list of the following:

- Covered services
- Clinical submission categories
- Common reasons for rejected and returned claims
- Reimbursement policies

Electronic Data Interchange (EDI) submission of provider claims

Providers may submit claims, eligibility inquiries, claim status inquiries and associated attachments using Electronic Data Interchange (EDI) by being a trading partner (TP) authorized by ODM or by contracting with an ODM authorized TP.
https://medicaid.ohio.gov/resources-for-providers/billing/trading-partners/trading-partners.

ODM Provider Network Management System Direct Data Entry

ODM's expectation is that for each Medicaid provider, Anthem system, and data are current and consistent with information held by ODM's system of record, the PNM system. Therefore, it is important that providers keep their records up to date in ODM's PNM system. With the PNM system as the ODM's system of record, MCOPs have been instructed to direct providers to update their ODM record in the PNM system when discrepancies are identified between the MCO's data and the PNM PMF. Anthem is instructed by ODM to not accept changes from providers into their own systems that are inconsistent with PNM system data shared through the PNM for their Medicaid line of business.

Providers may submit eligibility inquiries through the Provider Network Management (PNM) system.
https://managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing

Submitting Clean Claims

Electronic Data Interchange (EDI) submission of provider claims

Providers may submit claims, eligibility inquiries, claim status inquiries and associated attachments using Electronic Data Interchange (EDI) by being a trading partner (TP) authorized by ODM or by contracting with an ODM authorized TP.
https://medicaid.ohio.gov/resources-for-providers/billing/trading-partners/trading-partners

Click to return to Table of Contents

Availity Direct Data Entry (DDE) submission of provider claims

Claims **must** be sent by providers electronically through ODM's Fiscal Intermediary (FI) via an ODM EDI Trading Partner or through Direct Data Entry on Availity which will pass provider claims to Anthem for processing. Claims submitted correctly the first time are called *clean*, meaning that all required fields have been completed and that the correct form was used for the specific type of service provided.

A claim submitted with incomplete or invalid information may be returned. Claims will be returned for incomplete or invalid information. Claims also may be returned if they are not submitted with the proper *HIPAA*-compliant code set. In each case, an error report will be sent to you, and the claim will not be sent through for payment. You and your staff are responsible for working with your EDI vendor to ensure that *errored out* claims are corrected and resubmitted.

Generally, there are two types of forms you will need for reimbursement. NOTE: Providers are required to *submit the electronic versions of these forms:*

- *EDI 837P claim* for professional services: **https://www.cms.gov/medicare/cms-forms/cms-forms**
- EDI 837I claim for institutional services: **www.cms.gov/Regulations-and-Guidance**

Please note: Using the wrong form or not filling out the form correctly or completely causes the claim to be returned, resulting in processing and payment delays. Paper claims cannot be accepted.

Special note: The submission of a clean claim should not be misconstrued as being a proper claim for payment. Audits (pre and post payment) can occur by different departments for which a repayment may be requested. Providers are advised to follow proper coding practices using the current procedural and medical policies available. Providers may be requested to produce medical record documentation supporting the claim(s) to validate payment.

Basic Billing Guidelines

In general, these are the basic billing guidelines for institutional claims submitted to Anthem:

- Use Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT) codes or revenue codes. Valid HCPCS, CPT, or revenue codes are required for all line items billed.
- Provide medical records. Medical records for certain procedures may be requested for determination of medical necessity.
- Use modifiers in accordance with your specific billing instructions.
- Use codes for unlisted procedures. Because some provider services or procedures are not found in CPT, specific code numbers for reporting unlisted procedures have been designated. When using an unlisted procedure code, include a description of the service to help us calculate the appropriate reimbursement. We may request the member's medical records.

Please note: *System edits are in place for electronic claims. Claims submitted improperly cannot be processed easily and most likely will be returned.*

If you are a behavioral health provider that holds multi-license, please review the ODM Behavioral Health Manual located at **https://bh.medicaid.ohio.gov/manuals** for the most up-to-date billing guidance.

All other providers are required to use modifiers as outlined by ODM **https://medicaid.ohio.gov/resources-for-providers/billing/billing**.

Billing Professional Claims

Overview

Providers can depend on efficient claims handling and faster reimbursement when they follow the Anthem professional and ancillary billing requirements. These requirements include reporting standard CPT and HCPCS codes. This chapter is broken down into health service categories to help you find the specific billing requirements and codes you will need for each.

For the most efficient claims processing, accurately completed claims are essential. Follow these general guidelines for claims filing:

- Indicate the billing provider name, address (including ZIP +4) and taxonomy code, as certified with Ohio Medicaid.
- Indicate the rendering provider's national provider identifier (NPI) number and taxonomy code, as certified with Ohio Medicaid. Missing or invalid numbers may result in nonpayment.
- Use the member's ID number from the ID card.
- All providers must be certified by Ohio Medicaid in order to bill Anthem.

Preventive medicine services for new patients

Preventive medicine services for a new patient include an initial, comprehensive preventive medical evaluation. This evaluation includes an age- and gender-appropriate history, examination, counseling, risk factor interventions, and the ordering of appropriate immunizations, laboratory, and diagnostic procedures. Preventive visits should be billed using the appropriate office visit code.

Preventive medicine services for established patients

Preventive medicine services for an established patient involve re-evaluation and management of existing conditions, if any. This exam includes an age- and gender-appropriate history, examination, counseling, risk factor interventions, and the ordering of appropriate immunizations, laboratory, and diagnostic procedures.

Physical, speech and occupational therapies

With the exception of skilled nursing facilities, all physical therapy, occupational therapy, and speech therapy services must be reported, regardless of whether services are rendered in a facility or clinic setting.

Please note: All physical, speech and occupational therapy services require prior authorization on the 31st visit.

Maternity services

Providers may bill only the individual maternity services that were actually provided.

Urgent care visits

Urgent care means nonscheduled, nonemergency services required to prevent serious deterioration of a patient's health as a result of an unforeseen illness or injury. Urgent care visits are reported using the CPT codes for *Office or Other Outpatient Services* and *Place of Service 20 – Urgent Care Facility* (location, distinct from a hospital emergency room, office or clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention).

Sterilization

Sterilization is any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing. Sterilization does not include medical procedures that may have the effect of producing sterility but were performed for an entirely different purpose, such as removal of a cancerous uterus or prostate gland. To qualify for reimbursement, the following conditions must be met:

- At least 30 days, excluding the consent and surgery dates, but not more than 180 days, must pass between the date of written consent and the surgery date.
- The *Consent for Sterilization* form can be found on the ODM website under:
    - Stakeholders & Partners > Legal and Contracts > Medicaid Forms

Click to return to Table of Contents

Please note: Payment cannot be made to providers of associated services, including hospitals, anesthesiologists, pathologists, and radiologists, unless the consent form is completed in an accurate and timely manner.

The following are required before performing sterilization:

- Patient has voluntarily given their consent to be sterilized.
- Patient was at least 21 years of age on the date informed written consent is obtained.
- Patient is not mentally incompetent.
- Patient is not institutionalized.
- At least 30 days, but no more than 180 days, have elapsed between the date of consent and the sterilization.
- Consent form used can be located at **https://opa.hhs.gov/sites/default/files/2022-07/consent-for-sterilization-english-2025.pdf**; no other form may be substituted.
- Dates on the consent form cannot be altered.

The following are the exceptions to the 30-day waiting period:

- The sterilization is performed during emergency abdominal surgery and at least 72 hours have passed since the member gave written informed consent for sterilization.
- In the case of premature delivery, the sterilization is performed at the time of premature delivery and written informed consent was given at least 30 days prior to the expected date of delivery and at least 72 hours before the premature delivery. The 30 days excludes the consent and surgery dates.

Hysterectomy

An *Acknowledgment of Receipt of Hysterectomy Information* form must be completed prior to a covered, nonemergency hysterectomy, except in the following circumstances:

- The member was already sterile.
- The hysterectomy was required as the result of a life-threatening emergency situation in which the physician determined that prior acknowledgment of receipt of hysterectomy information was not possible.
- The hysterectomy was performed during a period of retroactive member eligibility, and one of the following circumstances applied:
    - The member was informed before the surgery that the procedure would make her permanently incapable of reproducing.
    - The member was already sterile.
    - The member was in a life-threatening emergency situation that required a hysterectomy.
- The form can be found on the ODM website under:
    - Stakeholders & Partners > Legal and Contracts > Medicaid Forms

Please note: Payment cannot be made to providers of associated services, including hospitals, anesthesiologists, pathologists, and radiologists, unless the Acknowledgment of *Receipt of Hysterectomy Information* form is completed accurately and in a timely manner and submitted with your claim.

Termination of pregnancy

For termination of pregnancy procedures to be covered by the Medicaid program, the member must meet a requirement listed below:

- The abortion is directly and medically necessary to save the life of the woman. Prior to the termination of the pregnancy, the provider attests in a signed, written statement that, based on their best clinical judgment, the termination of pregnancy meets this condition.

Click to return to Table of Contents

- The abortion is due to sexual assault or incest. Prior to the termination of pregnancy, the provider attests in a signed, written statement, in their opinion, sexual assault or incest has occurred. The crime must be reported to law enforcement authorities.
- Due to a medical condition that existed prior to the abortion, the provider determines that the abortion is directly and medically necessary to prevent grave, long-lasting physical health damage to the woman. Prior to the termination of pregnancy, the provider attests in a signed, written statement that, based on their best clinical judgment, the termination of pregnancy meets this condition.

The provider must complete an *Abortion Certification Statement* attesting to one of the circumstances listed above. In the case of rape or incest, the provider must include evidence that the crime was reported to law enforcement authorities. The *Abortion Certification Statement* form must be faxed to Anthem's claims department, along with progress notes and any law enforcement documentation.

The form can be found on the ODM website under:

- Stakeholders & Partners > Legal and Contracts > Medicaid Forms

When a termination of pregnancy meets criteria for coverage, office visits and all other medically necessary related services are covered. Treatment for complications arising from a termination of pregnancy are covered, regardless of whether the procedure to terminate the pregnancy itself is covered, because the complications represent new conditions, and thus, the services are not directly related to the performance of the procedure to terminate the pregnancy.

Billing members for services not medically necessary

Providers are prohibited from collecting payment from Anthem members for Anthem covered benefits. Members may be billed for noncovered services if they accept financial responsibility, and the provider makes payment arrangements with them prior to delivery of the service. The following conditions must be met prior to delivery of the service:

- The member requests a noncovered service or a specific service or item that, in the provider's opinion, may not be reasonable or medically necessary.
- The provider obtains a written acknowledgement, prior to rendering services, verifying that the Anthem member was notified of financial responsibility for services rendered. The member's expected out of pocket costs must be outlined on the acknowledgment.
- The member signs and dates the acknowledgement, indicating that the member has been notified of their responsibility to pay for the requested service prior to services being rendered. This must occur at every appointment.

Billing Institutional Claims

Overview

Throughout this chapter, specific billing requirements are broken down into the following service areas:

- Emergency room visits
- Maternity
- Termination of pregnancy
- Inpatient acute care
- Inpatient sub-acute care
- Outpatient laboratory, radiology, and diagnostic services
- Outpatient surgical services
- Outpatient infusion therapy visits and pharmaceuticals

Inpatient hospital reimbursement is based on DRGs, which applies to the following:

- Acute care general hospitals
- Institutions for Mental Disease (IMD) hospitals, except state-operated IMD hospitals

The following are excluded from the DRG system and are paid under a hospital-specific daily rate:

- Rehabilitation hospitals
- State-operated IMD hospitals
- State-operated veterans hospitals

Payment for the following specialized inpatient services is exempt from the DRG-based payment system:

- Services provided at rehabilitation hospitals
- Services related to ventilator care, brain injury cases and certain other unusual cases
- Services provided to Department of Corrections inmates

We also have included helpful billing guidelines for the ancillary services used most often by providers, including diagnostic imaging. These ancillary services include the following:

- Ambulance services
- Ambulatory surgical centers
- Durable medical equipment
- Dialysis
- Laboratory and diagnostic imaging
- Skilled nursing facilities
- Home healthcare (including Personal Care Services)
- Hospice

Please note: A member's benefits may not cover some of these services; confirm coverage before providing service.

This chapter will review specific coding guidelines for the EDI 837I claim form for hospitals and healthcare facilities.

Please note: System edits are in place for electronic claims. Claims submitted improperly will be rejected.

Maternity services

The billing requirements for maternity care apply to all live and stillbirth deliveries. Payment for services includes but is not limited to:

- Room and board for mother (including nursing care)
- Delivery room/surgical suites
- Equipment
- Laboratory
- Pharmaceuticals
- Radiology
- Other services incidental to admission

The maternity care rate covers the entire admission. If an admission is approved for extension beyond the contracted time limit for continuous inpatient days, the billing requirement for the entire admission shifts to inpatient acute care. This applies to each approved and medically necessary service day. Therapeutic termination of pregnancy, treatment for ectopic and molar pregnancies, and similar conditions are excluded from payment under this rate.

Inpatient acute care

All hospital services are considered to be part of a single, continuous inpatient stay when the services occur contiguously, and the member is eventually granted inpatient status. On an inpatient claim, providers are required to include all services provided during an outpatient visit that are contiguous with an inpatient stay for the member. Most covered services provided during an inpatient stay are hospital inpatient services that are included in the DRG-based payment system. The following hospital services also are considered part of the DRG-based payment system:

- Drugs, except take-home drugs on the date of discharge
- Services by independent therapists, (PT, OT, SLP, etc.)
- Services of residents and interns
- Services provided by another hospital (except on the date of admission and discharge)
- Services provided by social workers and substance use counselors
- Technical services by independent imaging groups (X-ray, MRI, etc.)
- Technical services provided by a nonhospital laboratory

Please note: Prior authorization is required for all Elective Inpatient admissions except standard vaginal delivery and cesarean sections.

Inpatient sub-acute care

The billing requirements for inpatient sub-acute care include each approved and medically necessary service day in a licensed and accredited facility at the appropriate level of care.

Sub-acute care includes levels of inpatient care less intensive than those required in an inpatient acute care setting.

Covered services include but are not limited to:

- Room and board (including nursing care)
- Equipment
- Laboratory
- Pharmaceuticals
- Radiology
- Supplies
- Other services incidental to the admission

Please note: All sub-acute admissions require prior authorization and a treatment plan. The treatment plan must accompany the admission and include:

- Functional, reasonable, objective, and measurable goals within a predictable time frame for each skilled discipline.
- A discharge plan and customized options identified and implemented from the admission date.
- Weekly summaries for each discipline.
- Biweekly conference reports.

Outpatient hospital diagnostic testing, laboratory, and therapeutic services

Diagnostic testing, laboratory and therapeutic services are considered outpatient hospital services when provided by a licensed hospital and ordered by a physician as a result of a member's visit to the outpatient hospital. The member may not be a hospital inpatient.

Some laboratory services are not processed through the Enhanced Ambulatory Patient Grouping (EAPG) system and are reimbursed at the lower of the usual and customary charge or the maximum allowable fee. Outpatient

hospitals may receive reimbursement for laboratory services resulting from specimens transferred from a source outside the hospital when the hospital laboratory is separately enrolled as an independent laboratory.

The following sections provide special billing requirements for each.

Note: Because the member's benefits may not cover all the services listed, confirm benefit coverage first.

Ambulance services

Ambulance providers, including municipalities, should use the *EDI 837P* claim form to bill for ambulance services. Ambulance providers are required to report pick-up and drop-off addresses on the claim form. Addresses must include street number, street name, city, state, and ZIP code.

Ambulatory surgical centers

Per Medicaid guidelines for outpatient surgery delivered in an Ambulatory Surgery Center prior authorization may be required.

Durable medical equipment

Durable medical equipment (DME) providers must use the EDI 837P claim. Billing for custom-made DME, prescribed to preserve bodily functions or prevent disability, requires pre-service review. Without such review, claims for DME will be denied.

Please note: The presence of an HCPCS code does not necessarily mean that the benefit is covered or that payment will be made. Some DME codes require additional information for prior authorization review. DME billing requires a differentiation between rentals and purchased equipment as well as specific codes and modifiers. Special guidelines for DME billing include:

- Use HCPCS codes for DME or supplies.
- Use an unlisted or miscellaneous code, such as E1399, when an HCPCS code does not exist for a particular item of equipment.
- Use valid codes for DME and supplies. If valid HCPCS codes exist, unlisted codes will not be accepted.
- Attach the manufacturer's invoice to the claim if using a miscellaneous or unlisted code. The invoice must be from the manufacturer, not the office making the purchase.

Please note: Catalogue pages are not acceptable as a manufacturer's invoice.

Durable medical equipment rentals

Some DME is dispensed on a rental basis and requires medical documentation from the prescribing provider. Rented items remain the property of the DME provider until the purchase price is reached. Charges for rentals exceeding the reasonable charge for a purchase are not accepted. Rental extensions may be obtained only on approved items.

Please note: DME providers should use normal equipment collection guidelines. Anthem is not responsible for equipment not returned by members.

Durable medical equipment purchase

Most DME may be purchased unless otherwise specified at the time of review by our Medical Management department.

Dialysis

With the exception of a limited number of emergency dialysis treatments, hospital providers are required to be separately enrolled as a Medicaid end-stage renal disease (ESRD) provider with a specialty of "Hospital

Affiliated" to receive reimbursement for renal disease-related services. Hospitals submitting claims under their hospital enrollment (not their ESRD enrollment) may receive reimbursement for providing up to three emergency dialysis treatments for a member per calendar year. These dialysis treatments are meant for emergency services only and not for a member with chronic renal failure.

Home infusion therapy

Supplies and equipment, such as infusion pumps associated with the IV, may be separately reimbursed by Anthem.

Skilled nursing facilities

All skilled nursing facility care requires prior authorization. Contact Anthem's Medical Management department for prior authorization and bill using the EDI 837I claim.

SNF providers may submit claims for Therapies (in other words, OT, PT, SLP), certain DME, and certain DMS under the nursing home NPI.

Hospice

When billing for hospice services, use the EDI 837I claim. Hospice services do not require Prior Authorization.

Valid Institutional Bill Types Include:

- 081x — Special Facility Hospice (non-hospital based)
- 082x — Special Facility Hospice (hospital based)

Valid Value Codes Include:

- 61 — Location Where Service is Furnished (HHA and Hospice)
  G8 — Facility where inpatient hospice service is delivered

Please Note: When value code G8 is billed, the NPI of the Facility along with their Name must be billed in box 80 Remarks on UB

Claim form	Service	Billing guidelines	Payment
HCFA — professional	Hospice R&B T2046	Must bill Nursing Facilities NPI in box 32a & the Name of the nursing facility in which the services were delivered in box 32	95% Published Skilled Nursing Facility Rate (+/- contract percentage)
HCFA — professional	Hospice R&B Private Room T2046 XP	Must bill Nursing Facilities NPI in box 32a & the Name of the nursing facility in which the services were delivered in box 32	95% Published Category 1 Private Room Rate (+/- contract percentage)
HCFA — professional	Hospice R&B Private Room T2046 XU	Must bill Nursing Facilities NPI in box 32a & the Name of the nursing facility in which the services were delivered in box 32	95% Published Category 2 Private Room Rate (+/- contract percentage)

Click to return to Table of Contents

Claim form	Service	Billing guidelines	Payment
UB — institutional	Routine Home Care per day (days 1-60 & 61+) Rev 0651/T2042	Bill Type - 081x or 082x Value code - 61 & *ODM specified SSA/State County Code 1 line per DOS	100% **Compliant & Non-Compliant CBSA rates (+/- contract percentage)
UB — institutional	Continuous Home Care per hour Rev 0652/T2043	Bill Type - 081x or 082x Value code - 61 & *ODM specified SSA/State County Code 1 line per DOS	100% **Compliant & Non-Compliant CBSA rates (+/- contract percentage)
UB — institutional	Service Intensity Add-on RN - Rev 0551/G0299 SW - Rev 0561/G0155	Bill Type - 081x or 082x Value code – 61, *ODM specified SSA/State County Code & Patient Discharge Status 40 1 line per DOS	100% **Compliant & Non-Compliant CBSA rates (+/- contract percentage)
UB — institutional	Inpatient Respite care per day Rev 0655/T2044	Bill Type – 081x or 082x Value code - G8 & *ODM specified SSA/State County Code	100% **Compliant & Non-Compliant CBSA rates (+/- contract percentage)
UB — institutional	General Inpatient care per day Rev 0656/T2045	Bill Type – 081x or 082x Value code - G8 & *ODM specified SSA/State County Code	100% **Compliant & Non-Compliant CBSA rates (+/- contract percentage)
UB — institutional	Vent-dependent – full rate for meeting VAP threshold Rev 0419 with diagnosis code Z99.11	Bill Type – 081x or 082x Nursing Facility NPI - [Name] billed in box 80 Remarks	95% Published Skilled Nursing Facility Rate (+/- contract percentage)
UB — institutional	Vent weaning – full rate for meeting VAP threshold Rev 0410 with diagnosis code Z99.11	Bill Type – 081x or 082x Nursing Facility NPI - [Name] billed in box 80 Remarks	95% Published Skilled Nursing Facility Rate (+/- contract percentage)
UB — institutional	Vent-dependent rate – 5% reduction for not meeting VAP threshold Rev 0419 with diagnosis code Z99.11	Bill Type – 081x or 082x Nursing Facility NPI - [Name] billed in box 80 Remarks	90% Published Skilled Nursing Facility Rate (+/- contract percentage)
UB — institutional	Vent weaning rate – 5% reduction for not meeting VAP threshold Rev 0410 with diagnosis code Z99.11	Bill Type – 081x or 082x Nursing Facility NPI - [Name] billed in box 80 Remarks	90% Published Skilled Nursing Facility Rate (+/- contract percentage)
UB — institutional	Physician Services (when employed by Hospice) Rev 0657/ +CPT/HCPCS Also needs to report Attending Phys or Other Phys NPI & Name	Bill Type - 081x or 082x 1 line per DOS	100% Appendix DD rates (+/- contract percentage)

EDI 837I claim

All Medicaid approved facilities should bill Anthem using the most up-to-date version of the EDI 837I claim form. All fields must be completed using standardized code sets. These code sets are used to ensure that claims are processed in an orderly and consistent manner. HCPCS provides codes for a variety of services and consists of Level I and Level II codes:

- Level I: CPT codes determined by the AMA and represented by five numeric digits.
- Level II: Other codes identifying products, supplies and services not included in the CPT codes such as ambulance services and DME. Sometimes referred to as the alphanumeric codes because they consist of a single alphabetical letter followed by four numeric digits.

In some cases, two-digit/character modifier codes should accompany the Level I or Level II coding.

Home Healthcare/Personal Care/Private Duty Nursing

All home care and select DME items require prior authorization, please see the provider look up tool for prior authorization requirements.

Please note: When billing for supplies and equipment used in a home healthcare visit, refer to the **durable medical equipment** section of this chapter for billing requirements.

Electronic Visit Verification (EVV)

EVV is used by caregivers for some home- and community-based services to document the time services begin and end. The Ohio Department of Medicaid provides an (EVV) system at no cost to all providers through Sandata. Agency providers may choose to use an alternate (EVV) system but must be approved by ODM prior to use. The *21st Century Cures Act (Cures Act)* requires states to use electronic visit verification (EVV) for home health and personal care services.

The HCPC codes which require providers to track visits through EVV are as follows:

G0151	T1000
G0152	T1001
G0153	T1025
G0156	T1019
G0299	T1002
G0300	T1003
	S5125

Your claim visit information is required to match the information submitted to Sandata's EVV system Although a claim may be paid, ODM may require Anthem to deny future claims where the claim visit details do not match EVV visit details.

For additional information on EVV refer to ODM Website: **Electronic Visit Verification | Medicaid (ohio.gov)**

Revenue codes

Revenue codes are required for all institutional claims.

Institutional inpatient coding

For institutional inpatient coding, use these guidelines:

- Use current applicable ICD and procedure codes in Boxes 74 through 74e of the *EDI 837I* claim form when the claim indicates that a procedure was performed.

Click to return to Table of Contents

- Use modifier codes when appropriate; refer to the current edition of the provider's CPT manual published by the AMA.
- Refer to your Provider Agreement for diagnosis-related group (DRG) information.

Institutional outpatient coding

For institutional outpatient coding, use the guidelines in the following code manuals:

- The Current Procedural Terminology manual published by the AMA.
- The Healthcare Common Procedure Coding System published by the Centers for Medicare and Medicaid Services (CMS).

Please note: When using an unlisted CPT/HCPCS code, provide the name of the drug or medication and National Drug Code (NDC).

International Classification of Diseases, 10th Revision (ICD-10)

As of October 1, 2015, ICD-10 became the code set for medical diagnoses and inpatient hospital procedures in compliance with *HIPAA* requirements and in accordance with the rule issued by the U. S. Department of Health and Human Services (HHS).

What is ICD-10?

International Classification of Diseases, 10th Revision (ICD-10) is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaces the International Classification of Diseases, 9th Revision (ICD-9), which was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes, and in the United States, the codes are the foundation for documenting the diagnosis and associated services provided across healthcare settings.

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

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

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

Anthem Medicaid EDI Payer ID

0022147

Electronic Remittance Advice (835)

The 835 (Electronic Remittance Advice) eliminates the need for paper remittance reconciliation. To receive an 835, registration with ODM is required. Please work with your EDI vendor to complete this **registration** form.

Providers may also access their ERAs through the PNM Portal or via the EDI Gateway through a Trading Partner. Images of the providers remittance advice can be viewed on Availity Remittance Viewer or through the PNM Portal.

Electronic Funds Transfer (EFT)

Electronic claims payment through electronic funds transfer (EFT) is a secure and fast 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.

Click to return to Table of Contents

Use EnrollSafe (**https://enrollsafe.payeehub.org**) to register and manage EFT account changes. If a provider does not enroll in EFT, they will receive a paper check or virtual card.

National Provider Identifier

The national provider identifier (NPI) is a 10-digit, all-numeric identifier. NPIs are issued only to providers of health services and supplies. As a provision of *HIPAA*, the NPI has been established to improve efficiency and reduce fraud and abuse.

NPIs are divided into two types:

- Type one: individual providers
- Type two: institutional providers

Providers may apply for an NPI online at the National Plan and Provider Enumeration System (NPPES) website: **https://nppes.cms.hhs.gov**.

The following websites offer additional NPI information:

- CMS: **www.cms.gov**
- NPPES: **https://nppes.cms.hhs.gov**
- Workgroup for Electronic Data Interchange: **www.wedi.org**
- National Uniform Claims Committee: **www.nucc.org**

Providers Not Enrolled with ODM

To be reimbursed for services by Anthem, providers must complete Ohio Medicaid's provider enrollment process. To begin the process, visit **https://medicaid.ohio.gov/resources-for-providers/enrollment-and-support/enrollment-and-support:**

- Provider contacts the health plan requesting to join the network. The health plan may also contact providers directly should additional recruitment, to improve access, be needed.
- The health plan will confirm using ODM files that the provider is currently enrolled as an approved Medicaid provider.
- If applicable, contracts will be created and sent to providers for review and signature.
- Upon receipt of signed agreement, the health plan will review, countersign, and send provider information to be loaded into the health plan's systems.
- Provider will be sent a welcome letter as well as a copy of their executed Agreement with the health plan.

Please note: Anthem is not responsible for a claim never received through ODM's FI. If a claim is submitted inaccurately, prolonged periods before resubmission may cause you to miss the filing deadline. Claims must pass basic edits to be considered received. To avoid missing deadlines, submit clean claims as soon as possible after delivery of service.

Timely filing requirements

Providers will have 365 days to timely file a claim, including any timely filing exceptions, in accordance with Ohio Administrative Code (OAC) rule 5160-1-19.

If the member has other health insurance that is primary, timely filing is counted from the date of the explanation of payment of the other health insurance.

Claim forms and filing limits

Refer to your Anthem provider contract to confirm timely filing limits, which may be different from what is stated below.

Form	Type to be billed	Time limit to file

EDI 837 Professional (P)	• Physician, physician groups and other professional services
	• Specific ancillary services, including:
	  ○ Audiologists
	  ○ Ambulance
	  ○ Ambulatory surgical center
	  ○ Dialysis
	  ○ Durable medical equipment (DME)
	  ○ Diagnostic imaging centers
	  ○ Hearing aid dispensers
	  ○ Laboratories
	  ○ Mental health and substance use clinics
	  ○ Occupational therapy
	  ○ Orthotics
	  ○ Physical therapy
	  ○ Speech therapy
	
	Some ancillary providers may use EDI 837 Institutional (I)if they are ancillary institutional providers. Ancillary charges by a hospital are considered facility charges.
	
	All claims must be submitted electronically. Paper claims are not accepted.
		Submit within 365 days from date of service.

EDI 837 Institutional (I)	• Skilled nursing facility (SNF) • Hospitals, hospices, institutions, and home health services • All claims must be submitted electronically. Paper claims are not accepted	Submit within 365 days of service date or date of discharge if the services are related to an inpatient stay.

Other filing limits

Action	Details	Timeframe
Third-party liability or coordination of benefits (COB)	If the claim has third-party liability, COB or requires submission to a third party before submitting to Anthem, timely filing is counted from the date of the explanation of payment of the other carrier.	Submit within 365 days from date of service.
Claim correspondence or corrected claim	If we request additional information or a correction to a claim, a claim follow-up is needed, and you must submit a corrected claim through ODM's FI.	Return the requested information within 365 days from the date of service
Provider claim disputes	Provider claim disputes are any provider inquiries, complaints, appeals, or requests for reconsiderations ranging from general questions about a claim to a provider disagreeing with a claim denial. We have several options to file claim payment disputes: • Disputes can be submitted through the provider website: **https://providers.anthem.com/oh** (Select Login or Register to access the secure site.). Through Availity Essentials, you can upload supporting documentation and receive immediate	Submit within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later.

Click to return to Table of Contents

Action	Details	Timeframe
	acknowledgement of your submission. Locate your claim using Claim Status and select the Dispute button to initiate then select "Go To Request" to complete the dispute request. The dispute can be tracked on the Appeals dashboard. • **Verbally** (for reconsiderations and claim payment appeals): Call Provider Services at **833-727-2170** (Monday to Friday, 8 a.m. to 8 p.m. ET).If you need to include supporting documentation (in other words, EOB, Consent Form, Medical Records, etc.) please do not use this option. • **Written** (for reconsiderations and claim payment appeals): Mail all required and supporting documentation to: Anthem Blue Cross and Blue Shield Payment Dispute Unit **P.O. Box 62500** **Virginia Beach, VA 23466** 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 number or TIN • The member's name and their Anthem ID number • A listing of disputed claims including the Anthem claim number and the date(s) of service(s) • All supporting statements and documentation	

External Medical Review

After exhausting the Anthem provider claims dispute resolution process, a provider may request an external medical review (EMR) if the claim payment denial, limitation, reduction, suspension, or termination was based on medical necessity. For more information on EMR, please see the Utilization Management section of this manual.

Monitoring Claims

After submitting electronic claims through an ODM EDI authorized trading partner or Direct Data Entry through Availity Essentials, you can monitor the claim by:

- Access the secure provider website, Availity Essentials:
  - Access Availity Essentials, the secure provider website **Availity.com**. Select **Login** or **Register** to access the secure site.
  - Under the *Claims & Payment* menu, select **Claim Status** to monitor your claim.

Electronic Response Reports

If claims are not in a *HIPAA*-compliant transaction code set or cannot be processed due to billing errors, your claim will be rejected. An EDI error report will be returned to ODM for your clearinghouse or vendor to retrieve,

and your claim will not be sent through for payment. Review the error report, make the necessary changes and file again.

Explanation of Benefits

Providers should encourage members to protect their ID cards as they would a credit card, to always carry their health benefits card, and report any lost or stolen cards to the Anthem as soon as possible. Understanding the various opportunities for fraud and working with members to protect their health benefit ID card can help prevent fraudulent activities. If you or a patient suspect ID theft, call the compliance hotline at **833-727-2170**. Providers should instruct their patients who suspect ID theft to inspect their *Explanation of Benefits (EOBs)* for any errors and then contact Member Services if something is incorrect.

Payment in Full Information

Medicaid Hold Harmless

Provider agrees that Plan's payment constitutes payment in full for any Medicaid Covered Services rendered to Medicaid Members. Provider agrees it shall not seek payment from the Medicaid Member, their representative or the State for any Health Services rendered pursuant to the Provider Agreement, with the exception of Cost Shares, if any, or payment for non-Medicaid Covered Services otherwise requested by, and provided to, the Medicaid Member if the Medicaid Member agrees in writing to pay for the service prior to the service being rendered. The form of agreement must specifically state the admissions, services or procedures that are non-Medicaid Covered Services and the approximate amount of out of pocket expense to be incurred by the Medicaid Member. Provider agrees not to bill Medicaid Members for missed appointments while enrolled in the Medicaid Programs.

Member Copayments and Balance Billing

There are no copayments for MyCare members. Members may not be balanced billed by providers for Medicaid covered services. This means that providers may not collect payment from a member for covered services above the amount Anthem pays to the provider.

A member may request a non-covered service or a covered service for which prior authorization was denied. When prior authorization of a covered service is denied, the provider must establish and demonstrate compliance with the following before collecting payment from the member:

- Establish that prior authorization was requested and denied before rendering service.
- Request a review of Anthem's authorization decision.
- Notify the member that the service requires prior authorization, and Anthem has denied authorization. If out-of-network, the provider also must explain to the member that covered services may be available without cost when provided by an in-network provider. Prior authorization for out-of-network services is required.
- Inform the member of their right to file a grievance if the member disagrees with the decision to deny authorization.
- Obtain in writing from the member approval to bill them for a non-covered or denied covered service which clearly explains the member will be responsible for payment of such services.

The charge for a service may be collected from the member if the following conditions are met prior to the delivery of that service:

- The member accepts responsibility for payment, and the provider and member make payment arrangements for the service in writing with member's signature.
- If the provider uses a waiver to establish member responsibility for payment, the waiver must meet the following requirements:
    - The waiver is signed only after the member receives appropriate notification and before services are rendered.

- The waiver does not contain any language or condition to the effect that if authorization is denied, the member is responsible for payment.
- A waiver must be obtained for each encounter or member visit that falls under the scenario of the noncovered services. Providers may not use nonspecific patient waivers.
- The waiver must specify the date services were provided and which services fall under the waiver's application.
- The waiver must show the cost of the services and have a payment plan established.

The provider has the right to appeal a denial of Anthem payment resulting from a denial of authorization. However, claim appeals of this type will be reviewed according to timely filing requirements and clinical criteria listed under **Utilization Management Appeals** in Chapter 6: Covered Services of this Provider Manual.

Claims Payment Disputes

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.

Provider claim disputes include any level of dissatisfaction with claims determination such as reconsideration, appeals, and escalated provider claim inquiries. Providers may file a claim dispute within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later.

Providers may submit claim disputes verbally or in writing, including through the provider portal.

After exhausting Anthem's provider claims dispute resolution process, a provider may request an external medical review (EMR) if the claim payment denial, limitation, reduction, suspension, or termination was based on medical necessity. For more information on EMR, please see the Utilization Management section of this manual.

In cases where your claim is denied, the consent of a Member who received the services is not required for you to dispute the denial of the claim. You may pursue a claim dispute based on non-payment for rendered services under the terms and conditions outlined in your contract with Anthem. The Member who received the services is not required to sign an authorized representative form, or provide other forms of written consent, for you to dispute the denied claim for payment.

A claim payment dispute may be submitted for multiple reason(s) including, but not limited to:

- Contractual payment issues.
- Inappropriate or unapproved referrals initiated by providers.
- Retrospective review.
- Disagreements over reduced or zero-paid claims.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Experimental/investigational procedure issues.
- Claim data issues.
- Timely filing issues*

* Anthem 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.

If a provider disagrees with the outcome of a claim decision, the provider may use the claims payment disputes process to challenge the decision. Submit a verbal or written request to Anthem for reconsideration. The guidance below will be used in determining the appropriate submission method.

The Anthem provider payment dispute process consists of two internal steps.

1. **Claim payment reconsideration:** It is the first step in the Anthem 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:** It is the second step in the Anthem provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment dispute.

Claim payment reconsideration

The first step in the Anthem claim payment dispute process is called the reconsideration. The reconsideration 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 through our provider website, verbally and in writing within 12 months from the date of service (DOS) or 60 calendar days from the date on the *Explanation of Payment* (*EOP*) (see below for further details on how to submit). Reconsiderations filed more than 365 calendar days from the DOS or 60 calendar days from the *EOP*, whichever was later, 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, it will be reviewed by appropriate clinical Anthem professionals.

Anthem will make every effort to communicate the claims payment reconsideration results within 30 business days for medical necessity determinations and within 15 business days for all other determinations from receipt of the Reconsideration. If additional time is required to make a determination, a status update will be sent every five (5) business days beginning on the 15th business day until the dispute is resolved.

We will send you our decision in a determination letter, which will include:

1. A statement of the provider's reconsideration request.
2. A statement of what action Anthem intends to take or has taken.
3. The reason for the action.
4. Support for the action including applicable statutes, regulations, policies, claims, codes, or provider manual references.
5. An explanation of your right to request a claim payment appeal within 12 months from the date of service (DOS) or 60 calendar days from the date of the determination letter.
6. An address to submit the claim payment appeal.
7. A claim dispute tracking number.

If the decision results in a claim adjustment, the payment, and *Explanation of Payment* (*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.

We accept claim payment appeals through our provider website, in writing or verbally within 12 months from the date of service (DOS) or 60 calendar days after the payment, denial or partial denial of a timely claim submission, whichever is later.

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. Please note, we cannot process a claim payment appeal without a reconsideration on file. If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate clinical Anthem professionals.

Anthem will make every effort to resolve the claim payment appeal within 15 business days of receipt. If additional time is required to make a determination, a status update will be sent every five (5) business days beginning on the 15th business day until the dispute is resolved.

The claim payment appeal determination letter will include the below information, as well as next steps if the provider disagrees with the resolution, including the opportunity for external medical review if the claim denial was due to lack of medical necessity:

1. A statement of the provider's claims payment appeal request.
2. Date of initial filings of concern.
3. A statement of what action Anthem intends to take or has taken.
4. The reason for the action.
5. Support for the action including applicable statutes, regulations, policies, claims, codes, or provider manual references.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

Medical necessity appeal

The medical necessity appeal is your initial request to investigate the outcome of a finalized claim related to medical necessity.

We accept medical necessity appeals through our provider website, in writing or verbally within 12 months from the date of service (DOS) or 60 calendar days from the date of the finalized claim.

When submitting a medical necessity appeal, please include as much information as you can to help us understand why you think the finalized claim was in error. Please note, we cannot process a medical necessity appeal without an adverse decision. Medical necessity appeals will be reviewed by appropriate clinical Anthem professionals.

Anthem will make every effort to resolve medical necessity appeals within 30 business days of receipt. If additional time is required to make a determination, a status update will be sent every five business days beginning on the 15th business day until the appeal is resolved.

The medical necessity determination letter will include the below information, as well as next steps if the provider disagrees with the resolution, including the opportunity for external medical review if the claim denial was due to lack of medical necessity:

1. A statement of the provider's medical necessity appeal request.
2. Date of initial filings of concern.
3. A statement of what action Anthem intends to take or has taken.

Click to return to Table of Contents

4. The reason for the action.
5. Support for the action including applicable statutes, regulations, policies, claims, codes, or provider manual references.

If the decision results in a claim adjustment, the payment and EOP will be sent separately.

How to Submit a Claim Payment Dispute

Both participating and nonparticipating providers can submit online, verbal, or written claim payment disputes within the above specified timeframes.

Complete the *Claim Payment Dispute Submissions Form* located on our website and note the following submission methods:

- **Online (reconsideration and claim payment appeal)**: Anthem can receive reconsiderations and claim payment appeals submitted through the provider website: **https://www.anthem.com/oh/provider/state-federal** (select Login or Register to access the secure site). You can upload supporting documentation, and you will receive immediate acknowledgement of your submission. Locate claim using Availity Essentials Claim Status, select dispute and **Go To Reques**t to complete.
- **Written (reconsideration and claim payment appeal):** Written reconsiderations and claim payment appeals should be mailed, along with the appropriate form, to:

  Anthem Blue Cross and Blue Shield
  Payment Dispute Unit
  P.O. Box 62500
  Virginia Beach, VA 23466

- **Verbal (reconsideration and claim payment appeal):** Verbal submissions may be submitted by calling Provider Services at **833-727-2170**.

Submission forms are available on the Anthem provider website in the *Forms* section.

Required Documentation for Claims Payment Disputes

When submitting the claim payment disputes, you must provide:

1. Your name, address, phone number, email, and either your NPI or TIN
2. The member's name and their Anthem or Medicaid ID number
3. A listing of disputed claims.
4. A detailed explanation of the reason for the appeal.
5. Supporting statements for verbal appeals and supporting documentation for written.

Payment of claims

After a claim is submitted through an ODM authorized trading partner, the Ohio Department of Medicaid will pass the claim to Anthem. Once received by Anthem, the following process will be performed by our system:

- The claim is analyzed for covered services.
- The appropriate payment to the provider is sent then a remittance advice statement is generated, summarizing the services rendered and the action taken.
- A claim disposition notices (CDN) is sent to the provider with the specific claims processing information.

The above information also applies to claims entered via Availity Direct Data Entry.

Anthem will make every effort to finalize a clean electronic claim submission within 21 calendar days from the date the claim is received.

Coordination of Benefits (COB)

If a member carries insurance through multiple insurers, Anthem will coordinate the benefits to ensure maximum coverage without duplication of payments. Providers must submit COB claims to the primary carrier before submitting to Anthem. After submitting the claim to the primary carrier, submit a claim for the total billed charges and include the primary carrier's remittance advice (RA). Indicate the other coverage information on the appropriate claim form. If you need to coordinate benefits, include at least one of the following items from the other healthcare program:

- Third-party RA
- Third-party letter explaining either the denial of coverage or reimbursement

COB claims received without at least one of these items will be mailed back to you with a request to submit to the other healthcare program first. Make sure the information you submit explains all coding listed on the other carrier's RA or letter. We cannot process the claim without this information. Timely filing is counted from the date of the explanation of payment of the other carrier.

No authorization is required for coordination of benefit (COB) claims.

Claims Overpayment Recovery and Refund Procedure

Anthem seeks recovery of all excess claim's payments from the person or entity to whom the benefit check was made payable. When an overpayment is discovered, Anthem initiates the overpayment recovery process by sending written notification. If you are notified by Anthem of an overpayment or discover that you have been overpaid, mail the refund check, along with a copy of the notification or other supporting documentation, to the following address:

Anthem Blue Cross and Blue Shield
P.O. Box 933657
Atlanta, GA 31193-3657

Fax: **866-920-1874**

If payment, a request for extended payment arrangement, or dispute request is not received within 30 calendar days from the date Anthem has notified a provider of an overpayment, Anthem will process the recovery and overpaid funds will be applied to the Provider's account as a negative balance.

If you believe the overpayment notification was created in error, contact Provider Services: **833-727-2170**.
For claims re-evaluation, send your correspondence to the address indicated on the overpayment notice. If Anthem does not hear from you or receive payment within 60 days, the overpayment amount is deducted from your future claims payments.

Returned or Rejected Claims

Claims returned for additional information

Anthem will send you a request for additional or corrected information when the claim cannot be processed due to incomplete, missing, or incorrect information.

Anthem also may request additional information retroactively for a claim already paid.

Click to return to Table of Contents

- Submit your claim with corrected or additional information through an ODM authorized trading partner or Availity Essentials with the appropriate attachment or through EDI indicating the appropriate attachment will be submitted separately.

Please note: Many of the claims returned for further information are returned for common billing errors.

Common reasons for denied, rejected, and returned claims

Problem	Explanation	Resolution
Member's ID number is incomplete.	Missing, incorrect format, number of characters, or not matching a member enrolled	Use the member's ID number on the ID card.
Duplicate claim submission	Overlapping service dates for the same service create a question about duplication. Claim was submitted to Anthem twice without additional information for consideration.	List each date of service, line by line, on the claim form. Avoid spanning dates, except for inpatient billing. Read remittance advices (RAs) and claim disposition notices (CDNs) for important claim determination information before resubmitting a claim. Additional information may be necessary.
Missing codes for required service categories	Current HCPCS and CPT manuals must be used because changes are made to the codes quarterly or annually. Manuals may be purchased at any technical bookstore, or through the American Medical Association (AMA) or the Practice Management Information Corporation.	Verify all services are coded with the correct codes (see lists provided). Check the codebooks or ask someone in your office who is familiar with coding.
Unlisted code for service	Some procedures or services do not have an associated code; use an unlisted procedure code.	Anthem needs a description of the procedure and medical records to calculate reimbursement. DME, prosthetic devices, hearing aids or blood products require a manufacturer's invoice.
By report code for service	Some procedures or services require additional information.	Anthem needs a description of the procedure and medical records to calculate reimbursement. DME, prosthetic devices, hearing aids and blood products require a manufacturer's invoice.
Unreasonable numbers submitted	Unreasonable numbers, such as "9999", may appear in the Service Units fields.	Check your claim for accuracy before submission.

Common Claim Issues Correspondence Vs. Payment Dispute

The following table provides examples of claim-related issues that should not go through the payment dispute reconsideration or appeal process. We would like to provide guidance on the most efficient way to resolve these common claim issues.

Click to return to Table of Contents

Note: To download a copy of the Claim Correspondence form, go to our provider website at **https://www.anthem.com/oh/provider/state-federal**.

Type of issue	What do I need to do?
EOP requests for medical records, supporting documentation (sterilization/ hysterectomy/abortion consent forms, itemized bills, and invoices), and **Submission of coordination of benefits (COB)/third-party liability (TPL) information**	Submit a Claim Correspondence form, a copy of your EOP and the supporting documentation to: Anthem Blue Cross and Blue Shield Claims Correspondence P.O. Box 62500 Virginia Beach, VA 23466

Clinical Submissions Categories

The following is a list of claims categories for which we routinely may require submission of clinical information before or after payment of a claim. If the claim:

- Involves prior authorization, predetermination or some other form of utilization review including but not limited to claims that are:
  - Pending for lack of prior authorization.
  - Involving medical necessity or experimental/investigative determinations.
- Requires certain modifiers.
- Includes unlisted codes.
- Is under review to determine if the service is covered; benefit determination cannot be made without reviewing medical records. This category includes but is not limited to specific benefit exclusions.
- Involves termination of pregnancy; all termination of pregnancy claims require a review of medical records to determine if: 1) the pregnancy is the result of an act of rape or incest or 2) the woman suffers from a physical disorder, physical injury, or physical illness, including a physical condition that endangers the woman's life and is caused by or arising from the pregnancy itself. In these cases, this condition would, as certified by a provider, place the woman in danger of death unless a termination of pregnancy is performed.
- Involves possible inappropriate or fraudulent billing.
- Is the subject of an internal or external audit, including high-dollar claims.
- Involves individuals under Case management or Condition care.
- Is under appeal or is otherwise the subject of a dispute, including claims being mediated, arbitrated, or litigated.

Other situations in which clinical information might be requested:

- Coordination of benefits
- Quality improvement/assurance efforts
- Recovery/subrogation
- Requests relating to underwriting, including, but not limited to, member or provider misrepresentation/fraud reviews and stop-loss coverage issues

Examples provided in each category are for illustrative purposes only and are not meant to represent an exhaustive list within the category.

Section IX: Care Coordination

Overview

Anthem's Care coordination program is a collaborative effort aiding both providers and members ranging from short-term assistance to meet care gaps to longer term, intensive, and holistic case management for our members with the most intense needs. Providers are encouraged to engage and direct development and provide feedback to our members' care plans. The program is designed to educate and assist members to become empowered, exercise their options to access the appropriate services, and optimize their healthcare benefits to meet their individual health needs. Anthem's Care coordination program ensures that all members have access to quality care coordination whether the member is receiving care from Anthem, a care coordination entity (CCE), the OhioRISE Plan, or a plan-contracted case management entity (CME). Anthem's care coordination identifies and addresses physical, behavioral, and psychosocial needs of our members.

Anthem's care coordination team includes a range of disciplines with complementary skills and knowledge to deliver a comprehensive, integrative program that addresses member's physical, behavioral, financial, and psychosocial needs. Registered nurses, some of whom are certified case managers, licensed behavioral health professionals develop the member's centered care plan, supplement provider's treatment plans and assist in navigating the healthcare system. This team consists of clinical and non-clinical team members who provide care coordination activities as described by ODM. Anthem ensures each member has a primary point of contact to coordinate each member's unique needs.

Please note: Our Care coordination department is sensitive to the cultural and linguistic diversity of our members and its impact on their interaction in the healthcare system. We encourage providers to become familiar with our cultural and linguistic training materials, available on the providers page of our website: **https://www.anthem.com/oh/provider/state-federal**. There are interpreters available to meet the needs of our members. If the provider requests an interpreter to be present at the time of the appointment with the member, Anthem makes the arrangements. Contact Provider Services at **833-727-2170**.

There are multiple ways Anthem members may be referred to case management services, including:

- Member or caregiver referral
- Discharge planner referral
- Practitioner referral,
- Medical management program referral, or
- Risk stratification and health risk assessment results.

Care Coordination focuses on the timely, proactive, collaborative, and member centric coordination of services for individuals identified with complex medical conditions. To facilitate linking members with services that meet their needs and achieve their goals, members are identified or referred for the Complex Case Coordination services by: Risk Stratification (Medical and Behavior Health)

Care Coordinator Responsibilities

When a member has been identified as having a condition that may benefit from care coordination, the care coordinator contacts the referring provider and member for input on completion of an initial assessment. Then, with the involvement of the member or the member's representative and the provider, the care coordinator develops an individualized care plan. The member-centric plan of care reflective of the identified gaps in care that will meet the goals of the member to improve their ability toward self-care management. The care plan is a living document for address members goals toward self-management including providing resources that may include coordinating of external community services.
The care coordinator will assist the member and the care team simultaneously to identify and accomplish members desired goals such as the following:

- Prioritized, measurable goals that consider the member or caregiver preferences and desired involvement in the care plan
- Barriers to meeting goals or complying with the care plan, if no barriers are identified the care plan is updated to indicate the member has identified no barriers
- A schedule for follow-up and communication with members that includes timeframe and contact method
- Member self-management plan that the member agrees to with documentation of the member's acknowledgement of an agreement with the actions
- Assessment of the member's progress against goals
- Resources to be utilized (both organization and community-based resources)
- Planning for continuity of care, including transitions of care and transfers
- Update as needed as to reflect new referral processes/resources
- Identify new member needs
- Use of a collaborative approach with all parties, including the member, member's Authorized or Designated Representative and physician.
- Care coordination will engage the family when appropriate in the design and care planning for the members.
- Identification and access to resources to address the social drivers of health (SDoH).

Care Coordination Qualification

Anthem's Care Coordination programs uses care coordinator for clinical care coordination and support for members for both physical and behavioral health. They additionally use outreach Specialists for non-clinical decision management and support. These roles have been adapted for the Ohio Medicaid Managed Care program to Care Coordinator, Care Coordinator+, Care Guide, and Care Guide+.

The qualifications for the roles of care coordinator, care coordinator+, social worker, and pharmacist require the healthcare professional to hold and maintain an unrestricted clinical license. Job descriptions provide specific qualifications for each role. To maintain compliance with accreditation requirements and standards of practice for care managers, qualifications must also include one of the following:

- Licensure or certification in a health or human services discipline that allows the professional to conduct an assessment independently as permitted within the scope of practice of the discipline.
- Three years of full time direct clinical care or any combination of education and experience, which would provide an equivalent background
- Or at least one of the following:
    - Certification as a care coordinator from the organizations approved list of certifications.
    - An associates or bachelor's (or higher) degree in a health or human services related field.
    - Current and unrestricted RN licensure.

Continued Access to Care

New Anthem members may receive services from out-of-network Medicaid-certified providers if certain guidelines are met. First, the provider must contact us to discuss the scheduled health services in advance of the service date. Second, the case must meet medical necessity.

Continuity of Care Process

Anthem's care coordination team promote continuity of care and integration of services for the member across a range of settings, including transitions of care. The interventions specified in the member's care plan provides the optimal benefit to address the multi-dimensional care needs of our members and to increase access to care which is critical to achieve continuity of care. Anthem's care coordination team is here to assist members in the

event they would like to change providers. The team will communicate with the current provider to ensure all care needs are met across the care continuum and care transitions with the new provider.

Section X: Reporting

Medical Records Standards

Medical records must be maintained in a manner ensuring effective and confidential member care and quality review. At Anthem, we perform medical record reviews upon signing a provider contract. We then perform medical record reviews at least every three years (unless there is suspected or confirmed fraud, waste, and abuse) to ensure that providers remain in compliance with these standards in accordance with OAC rule 5160-26-05.1.

Medical records should contain the appropriate documentation to support all levels of services billed and be submitted upon request for the validation of payment. Payment should not be construed as the claim(s) being appropriate. Audits can occur by different departments on a pre-payment or post-payment basis for which repayment(s) may be requested.

Medical records must be stored and retrieved in a manner that protects patient information according to the Confidentiality of Medical Information Act. This act prohibits a provider of healthcare from disclosing any individually identifiable information regarding a patient's medical history, treatment, or behavioral and physical condition without the patient's or legal representative's consent or specific legal authority.

Records required through a legal instrument may be released without patient or patient representative consent. Providers must be familiar with the security requirements of *the Health Insurance Portability and Accountability Act of 1996 (HIPAA)* and be in compliance. For more information on medical records standards, refer to **Chapter 15: Quality Assessment and Performance**.

Mandatory Reporting of Elder Abuse, or Domestic Violence

Providers must ensure their office staff is familiar with local reporting requirements and procedures regarding telephone and written reporting of known or suspected cases of abuse. All healthcare professionals must report any actual or suspected elder abuse or domestic violence immediately to the local law enforcement agency by telephone. In addition, providers must submit a follow-up written report to the local law enforcement agency within the time frames required by law.

Anthem Clinical Case Management associates (herein after "clinical associates") have a legal responsibility under state laws to report suspected events such as adult abuse or neglect in order to comply with professional standards of practice and statutory reporting requirements for licensed healthcare professionals.

Clinical case management (CM) associates who during contact suspect that a member is experiencing an emergency (medical and/or psychiatric in nature) should take the following action:

1. Strongly advise the member to contact their physician or go directly to the nearest hospital emergency department or call 9-1-1. The clinical CM associate is not expected to contact a physician or emergency department on the member's behalf, since this is the responsibility of the member. The clinical CM associate should follow-up with the member as appropriate for the situation.
2. In situations where life or safety is threatened, or in situations in which a prudent layperson, acting reasonably would believe an emergency exists (such as threats to harm self and/or others), the clinical CM associate will contact the local community emergency response system where the member lives.
3. If there appears to be a serious and imminent threat to health or safety to any person, any associate with such knowledge should take immediate steps to prevent or lessen the serious or imminent threat (for example, report the incident to 911, the local police department, paramedics).

Incident Reporting

Providers are required to ensure the immediate health and safety of members when becoming aware of abuse, neglect, exploitation, misappropriation greater than $500, and accidental/unnatural deaths. If actions were not taken to ensure the immediate health and safety of the members, the provider will do so immediately. Such actions may include calling police or emergency medical services or regulatory agencies such as the Ohio Department of Health. Providers are required to report these types of incidents to Anthem within 24 hours of becoming aware of the incident.

All Anthem associates will report all incidents including by not limited to abuse, neglect, exploitation, misappropriation of greater than $500 and unexplained death by entering into Anthem medical management system. Anthem will work with internal and external CM teams by creating supporting preventive plans and interventions. The internal CM and external CCEs will be trained on the Incident Management System reporting incidents according to the provider contract. Anthem will develop and implement safeguards, systems, and processes that detect, prevent, and mitigate harm and/or risk factors that could impact a member's health, safety, or welfare by placing services in place to address resources needed.

Anthem will identify, track, and analyze critical incidents to identify and address potential and actual quality of care and/or health and safety issues.

How to Submit an Incident to Anthem

To report an incident, please visit **https://www.anthem.com/oh/provider/state-federal**.

Healthcare Acquired Conditions (HCAC)

Anthem requires the identification of HCACs (see Exhibit C) through the submission of a Present on Admission (POA) indicator (see Exhibit A) for all diagnoses on inpatient facility claims as identified by CMS. If the POA indicator identifies an HCAC, the reimbursement for the episode of care may be reduced or denied

Other Provider Preventable Conditions (OPPC)

For professional providers and facilities, procedures identified as an OPPC, and all related services will be rejected or denied.

Providers should use the appropriate codes to report OPPCs. Erroneous surgical events occurring during an inpatient stay should be reflected on Type of Bill 0110 (no-pay claim) along with all services or procedures related to the surgery. All other inpatient procedures and services should be submitted on a separate claim. A condition defined as an OPPC for a particular member existing prior to the initiation of treatment for that member by that provider will not impact that provider's reimbursement.

Section XI: Member Eligibility/Rights and Responsibilities

Member Services: **833-727-2169 (TTY 711)**
Hours of operation: **Monday to Friday, 8 a.m. to 8 p.m. ET.**

Overview

Members should be clearly informed about their rights and responsibilities so they can make the best healthcare decisions. Members also have the right to ask questions about the way we conduct business, as well as the responsibility to learn about their healthcare plan coverage.

Given the increasing complexities of healthcare administration, widespread potential for fraud and abuse, and constant fluctuations in program membership, member eligibility should be verified before services are rendered every time a member comes in for services. To prevent fraud and abuse, providers should confirm the identity of the person presenting the ID card. Providers must also verify a member's eligibility before services are delivered and at every visit. Claims submitted for services rendered to non-eligible members will not be eligible for payment.

Verifying Member Eligibility

Providers can verify member eligibility by doing any one of the following:

- Log in to **Availity.com** and select **Patient Registration**, then **Eligibility and Benefits Inquiry** and enter the member ID.
- Log in to PNM Portal and enter the member's ID **here.**

Member ID Cards

Following enrollment, eligible enrollees will receive a member ID card. All Anthem members enrolled in Ohio Medicaid will receive an Anthem-issued ID card, which contains the following member information:

- Name
- Anthem member ID number
- Group number and plan code, if applicable
- RXBIN
- Telephone numbers for vital services to include:
    - Member Services.
    - 24/7 NurseLine.
    - Provider Services.
    - Pharmacy Services.

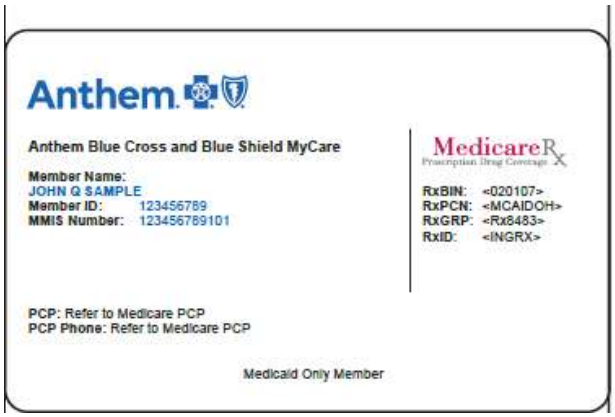
If a card is lost, members may receive replacement cards upon request through our Member Services.

Please note: At each member visit, providers must ask to see the member's ID card. This verification should be done before rendering services and before submission of claims to Anthem.

MyCare Ohio ID Card

This card identifies an Anthem **Medicaid Only** member.

Front



Back

This card identifies an Anthem **MyCare Ohio** member.

Front

Back

Member Rights

Anthem honors civil rights and provides covered services to all eligible members regardless of:

- Age.
- Color.
- Disability.
- Marital status.
- National origin.
- Race.
- Religion.
- Gender.
- Gender identity.
- Sexual orientation.
- Military participation.
- Arrest or conviction record.

All medically necessary covered services are offered to all members. All services are given in the same way to all members. All persons or groups who work with Anthem, or who refer or suggest services to members, shall do so in the same way for all members. Translation or interpretation services are offered free of charge for those members who need assistance.

Click to return to Table of Contents

Members have the right to:

- Ask for an interpreter and have one provided during any Medicaid covered service.
- Receive any information from the HMO provided in another language or another format.
- Receive healthcare services as provided for in federal and state law. All covered services must be available and accessible. When medically appropriate, services must be available 24 hours a day, 7 days a week.
- Receive information about the organization, its services, its practitioners, and providers and member rights and responsibilities.
- Receive information about treatment options and alternatives, including the right to request a second opinion. If an appropriately qualified network provider is not available, second opinion services from an out-of-network provider will be reimbursed at no charge to the member.
- Participate with their practitioners to make decisions about their healthcare, including refusing treatment.
- Have a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Be treated with respect and recognition of dignity and their right to privacy.
- Voice complaints or appeals about the organization or the care it provides.
- Make recommendations regarding the organization's member rights and responsibilities policy.
- Be free from any form of restraint or seclusion used as means of force, control, convenience, or retaliation.
- Request copies of their medical records from their providers.
- Amend medical records.

Member Responsibilities

Members have the responsibility to:

- Supply information (to the extent possible) that the Plan and its practitioners and providers need in order to provide care
- Show their ID card each time they receive medical care.
- Make or change appointments.
- Get to appointments on time.
- Call their PCP if they cannot make it to their appointment or if they will not be on time.
- Use the emergency room only for true emergencies.
- Pay for any services they ask for that are not covered.
- Treat their PCP and other healthcare providers with respect.
- Tell us, their PCP, and their other healthcare providers (to the extent possible) what they need to know to treat them.
- Do the things that keep them from getting sick.
- Follow the treatment plans members, their PCP, and their other healthcare providers agree on.
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Tell us if they:
    - Move.
    - Change their phone number.
    - Have a change in the number of people in their household.
    - Have other insurance.
    - Become pregnant.

Click to return to Table of Contents

Section XII: Access standards and access to care

Overview

This chapter outlines Anthem's standards for timely and appropriate access to quality healthcare. These standards help ensure that medical appointments, emergency services and continuity of care for new and transferring members are provided fairly, reasonably and within specific time frames.

Anthem monitors provider compliance with access-to-care standards on a regular basis. Failure to comply may result in corrective action.

General Appointment Scheduling

PCPs and specialists must make appointments for members according to the following scheduling standards:

Type of visit	Description	Minimum standard
Emergency service	Services needed to evaluate, treat, or stabilize an emergency medical condition.	24 hours, 7 days/week
Urgent Care (includes medical, behavioral health, and dental services)	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include but are not limited to sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain, and severe, non-resolving headache. Acute illness or substance dependence that impacts the ability to function but does not present imminent danger.	24 hours, 7 days/week within 48 hours of request
Behavioral health non-life threatening emergency	A non-life threatening situation in which a member is exhibiting extreme emotional disturbance or behavioral distress, has a compromised ability to function, or is otherwise agitated and unable to be calmed.	Within 6 hours
Behavioral health routine care	Requests for routine mental health or substance use treatment from behavioral health providers.	Within 10 business days or 14 calendar days, whichever is earlier
American Society of Addiction Medicine (ASAM) Residential/Inpatient Services – 3: 3.1, 3.5, 3.7	Initial screening, assessment, and referral to treatment.	Within 48 hours of request
ASAM medically managed intensive inpatient services – 4	Services needed to treat and stabilize a member's behavioral health condition.	24 hours, 7 days/week
Primary care appointment	Care provided to prevent illness or injury; examples include but are not limited to routine physical examinations, immunizations, mammograms, and pap smears.	Within 10 business days
Non-urgent sick primary care	Care provided for a non-urgent illness or injury with current symptoms.	Within 3 calendar days

Type of visit	Description	Minimum standard
Prenatal care – first or second Trimester	Care provided to a member while the member is pregnant to help keep member healthy, such as checkups and prenatal testing.	First appointment within 7 calendar days; follow up appointments no more than 14 calendar days after request
Prenatal care – Third trimester or High-risk pregnancy		Within 3 calendar days
Specialty care appointment	Care provided for a non-emergent/non-urgent illness or injury requiring consultation, diagnosis, and/or treatment from a specialist.	Within 6 weeks
Dental appointment	Non-emergent/non-urgent dental services, including routine and preventive care.	Within 6 weeks of request

Services for Members 21 Years of Age and Older

Nature of visit	Appointment standards
Initial health assessments	Within 90 days of enrollment
Preventive care visits after initial diagnosis	Within 60 days of request

Nondiscrimination and Office Hours

Providers must post a statement in their offices detailing hours of operation. These hours of operation must not discriminate against Anthem members enrolled in Medicaid. The statement must include the following:

- Waiting times for appointments
- Waiting times for care at facilities
- Languages spoken

The hours of operation that practitioners offer to Medicaid members to be no less than those offered to commercial members.

Interpreter Services

Anthem will ensure that members who need interpreter services have access to a telephone interpreter 24 hours a day, seven days a week, free of charge. Services include assistance during office visits and telephone assistance. To request interpreter services during business hours:

- Providers call Provider Services: **833-727-2170**.
- Members call Member Services: **833-727-2169, TTY: 711**

To request interpreter services after-hours, providers and members call the 24/7 NurseLine:

- Phone: **855-658-9249** (24 hours a day, 7 days a week)
- TTY: **711**

After-Hours Services

Anthem's policy, and the state of Ohio's requirement, is for our members to have access to quality healthcare services 24 hours a day, seven days a week. This kind of access means PCPs must have a system in place to ensure members may call after-hours with medical questions or concerns. Anthem monitors PCP compliance with after-hours access standards on a regular basis. Failure to comply may result in corrective action.

PCPs must adhere to the answering service and answering machine protocols defined in the following sections.

Answering service

Answering service or after-hours personnel must:

- Forward member calls directly to the PCP or on-call provider or instruct the member that the provider will contact the member within 30 minutes.
- Ask the member if the call is an emergency. In the event of an emergency, immediately direct the member to dial 911 or proceed to the nearest hospital emergency room.
- Have the ability to contact a telephone Interpreter for members with language barriers.
- Return all calls.

Answering machine messages

- May be used when provider office staff or an answering service is not immediately available
- Must instruct members with emergency healthcare needs to dial 911 or proceed to the nearest hospital emergency room
- Must provide instructions on how to contact the PCP or on-call provider in a nonemergency situation
- Must provide instructions in English, Spanish and any other language appropriate to the PCP's practice

24/7 NurseLine

Members may call the 24/7 NurseLine, our 24/7-information phone line, any time of the day or night to speak to a registered nurse. Nurses provide health information and options for any of the following:

- Authorization requests
- Emergency instructions
- Health concerns
- Local healthcare services
- Medical conditions
- Prescription drugs
- Transportation needs
- Access to interpreter services

Phone: **855-658-9249**
TTY: **711**

Section XIII: Member transfers and disenrollment

Overview

At Anthem, our members have the freedom to choose their most important link to quality healthcare: their doctor. After enrollment, we strongly encourage our members to select a PCP and remain with that provider because we believe in the positive impact of having a medical home. This home establishes a centralized hub from which all healthcare can be coordinated, no matter how many other caregivers become involved.

Occasionally, members may encounter barriers to effective relationships with their PCP. These obstacles may arise from geographical access, cultural and language differences, or simply personal preferences. Our members may change their PCP at any time, for any reason.

Members also have the right to change healthcare plans, as long as they follow specific rules and timelines. If a member requests disenrollment, Anthem will provide information and assistance in the disenrollment process, but a member must disenroll through the Ohio Department of Medicaid directly. Information about changing plans or disenrollment requirements may be found on ODM's website at **https://www.ohiomh.com/**.

We are committed to supporting providers' practices as well. Providers also have the right to request that a member be reassigned to another PCP under certain conditions and following specific guidelines.

Anthem notifies PCPs of changes in member assignments through PCP Assignment Reports. These reports are available on the Provider Online Reporting application that is accessed through Availity Payer Spaces, **Availity.com**. Providers also may call Provider Services: **833-727-2170**.

PCP-Initiated Member Transfers/Disenrollment

A PCP may request member reassignment to a different PCP by contacting Provider Services.

Anthem will conduct a thorough review of the request for reassignment to determine whether the cause and documentation are sufficient to approve the request. This review includes monitoring to ensure consistency with our guidelines and policies.

The provider is expected to coordinate service for up to 30 days after the date Anthem receives the change request form. Upon completing the PCP assignment change, we will forward the form and any other information related to the case to the Member Services representative. This representative informs the member of the change within five working days. The change will be effective the day Anthem enters the change into the system.

State Agency-Initiated Member Disenrollment

Contracted state agencies inform Anthem of membership changes by sending daily and monthly enrollment files in the HIPAA 834 format. These files contain all active membership data and incremental changes to eligibility records, as well as Anthem disenrolled members. Any discrepancies between the daily and monthly 834 files will be reported to ODM. Anthem will not term members by absence. Reasons for disenrollment may include:

- Admission to a long-term care or intermediate care facility beyond the month of admission and the following month (disenrollment is 30 days Medicaid)
- Change in eligibility status
- County changes
- Death
- Incarceration
- Loss of benefits
- Member has other nongovernment or government sponsored health coverage

- Permanent change of residence out of service area
- Voluntary disenrollment member transfers and disenrollment

Disenrollment requests based on the reasons outlined above require a referral to the member advocate in the health plan.

Member-Initiated PCP Reassignment

Members have the right to change their PCP at any time. When a member enrolls in Anthem, they may select a PCP or allow their PCP to be assigned. After that, if the member wants to make a change, they are instructed to call Member Services at **833-727-2169 (TTY 711)** to request an alternate PCP.

Anthem accommodates member requests for PCP reassignment whenever possible. Our staff will work with the member to make the new selection, focusing on special needs. Our policy is to maintain continued access to care and continuity of care during the transfer process. When a member calls to request a PCP change:

- The Member Services representative checks the availability of the member's choice. If the member can be assigned to the selected PCP, the Member Services representative will do so. If the PCP is not available, the representative will assist the member in finding an available PCP.
- Anthem notifies PCPs of member transfers through the PCP assignment report. These reports are available on Availity Essentials, our secure provider website at **Availity.com**. Select **Login** or **Register** to access the secure site.
- The effective date of a PCP change will be the same as the date of the member request.

Member-Initiated Disenrollment Process

When members enroll in our program, we provide instructions on disenrollment procedures. If a member asks a provider how to disenroll from Anthem, the provider should direct the member to call Member Services: **833-727-2169 (TTY 711).**

Please note: Providers may not take retaliatory action against any member for requesting transfer or disenrollment.

When Member Services receives a call from a member who wants to disenroll, we attempt to find out the reason for the request and determine if we can resolve the situation. If Member Services is unable to resolve the issue, a referral is made to the member advocate in the health plan. The member advocate makes the referral to the enrollment contractor for an enrollment change if unable to resolve the situation. The disenrollment must be completed by Ohio Department of Medicaid before the member can be disenrolled from Anthem.

Member Transfers to Other Plans

Members may choose a different healthcare plan on an annual basis during the open enrollment period. During the enrollment period, all Medicaid members may change to a different HMO if the member is not satisfied with the current plan. After the open enrollment period ends, members remain with their chosen healthcare plan for the remaining 12-month period.

Members who are already enrolled in a plan and would like to change to a different plan must meet one the following requirements:

- Member has been enrolled in their current plan for three months or less, or
- Member has attempted to resolve concerns with an Anthem case manager, but continue to have problems finding adequate care

If a member believes they meet one of these requirements, they must complete the change request at **https://www.ohiomh.com/home/changeplans**. If a member does not meet one of the requirements above and still wants to change plans, they may change plans during open enrollment each November.

Anthem-Initiated Member Disenrollment

Anthem also may request disenrollment for a member who has moved out of the service area. When a member moves out of our service area, they are responsible for notifying the Ohio Department of Medicaid of the new permanent address. Once Anthem receives an updated enrollment file showing the member has been disenrolled, Anthem will update our system to reflect the member's disenrollment with the effective date provided by ODM.

Section XIV: Quality assessment and performance improvement

Overview

Anthem's goal is continuous, measurable improvement in our delivery of quality healthcare. Following federal and state guidelines, we have a Quality Assessment and Performance Improvement (QAPI) program in place to advance our levels of readiness, service, and care. Our approach employs a deliberate and defined, science-informed approach that is responsive to member and provider needs and incorporates systematic methods to identify reliable approaches to improving population health and reducing health disparities. The QAPI program, aligned with Ohio's Medicaid Quality Strategy, includes the design and implementation of improvement projects in clinical and non-clinical areas that improve population health, including health equity, across all levels of care.

Focused populations include:

- Healthy adults
- Women and infant health
- Adults with behavioral health needs
- Persons with chronic conditions (for example, asthma, diabetes, hypertension

All providers are expected to participate in these studies as part of our mutual goal of providing responsive, cost-effective healthcare that improves our members' lives. The studies include:

- Participation in multi-disciplinary teams for problem solving
- Population studies
- Random sample-based studies
- Satisfaction surveys

We share information from these studies with providers and encourage constructive feedback. Based on the results of the previous year's QAPI program, Anthem reviews and assesses the program's effectiveness and develops a new work plan for next year's activities.

We also participate in national evaluations designed to gauge our performance and that of providers. An important measure of performance comes from the National Committee for Quality Assurance (NCQA), which annually reports the Healthcare Effectiveness Data and Information Set (HEDIS®) scores for healthcare plans throughout the country. This professional evaluation serves as a yearly report card and is a tool used by more than 90% of America's healthcare plans to rate performance across a wide spectrum of care and service areas, including:

- Member satisfaction with care access
- Member satisfaction with claims processing
- Customer service

Anthem uses the HEDIS data to identify areas for improvement and shares the results with providers. As a result, HEDIS summaries may be used by potential members to make comparisons before choosing a healthcare plan.

We also are committed to tracking preventable adverse medical events, also known as "never events," with the ultimate goal of eliminating these events.

Please note: If we determine that the quality of care or services provided by a healthcare professional is not satisfactory, Anthem may terminate the Provider Agreement and related addendums. We make this determination by reviewing member satisfaction surveys, care coordination data, member complaints or grievances, other complaints, or lawsuits alleging professional negligence, or quality-of-care indicators.

Quality Assessment and Performance Improvement Program

The QAPI program focuses on developing and implementing standards for clinical care and service, measuring conformity to those standards, and taking action to improve performance. The scope of the QAPI program includes, but is not limited to, the monitoring and evaluation of:

- Care and service provided in all health delivery settings.
- Internal organizational performance.
- Provider/member satisfaction.
- Provider promotion of preventive health programs and exams.
- Provider management of member health status.
- Provider site facilities and medical records.

Anthem develops an annual plan of quality improvement activities based on the results of the previous year's QAPI program evaluation. Then, we review, evaluate, and revise the QAPI program's effectiveness. The evaluation is a written description of the ability of Anthem to implement the QAPI program, meet program objectives, and develop and implement plans to improve the quality of care and service to our members.

Providers and practitioners must abide by Anthem's policies or *Provider Manual*, which contain provisions for the use of provider performance. Providers and practitioners are expected to cooperate with and support Anthem's QI activities of the QAPI program to improve the quality of care and services and member experience. Cooperation includes collection and evaluation of performance data, service measure, and participation in the organization's QI programs, and:

- Providing constructive feedback and input on proposed performance improvement initiatives.
- Participating in the facility and medical record audit process.
- Providing access to medical records for quality improvement projects and studies.
- Responding in a timely manner to requests for written information and documentation if a quality of care or grievance issue has been filed.
- Completing corrective action plans, when applicable.
- Using preventive health and clinical practice guidelines in member care.

Anthem does not delegate Quality Improvement activities but may use practitioner and/or provider performance data for quality improvement activities such as:

- Public reporting to consumers.
- Preferred status designation in the network (tiering) for narrow networks.
- Cost sharing for using preferred providers.

An overview of the QAPI program outcomes is posted on the provider website annually. You may also request a hard copy by calling Provider Services at **833-727-2170**.

Healthcare Effectiveness Data and Information Set

HEDIS is a national evaluation and core set of performance measurements gauging the effectiveness of Anthem and providers in delivering quality care. We are ready to help when providers and their office staff need training to participate in required HEDIS evaluations. Providers can request consultations and training in the following areas:

- Information about the year's selected HEDIS studies
- How data for those measures will be collected
- Codes associated with each measure
- Tips for smooth coordination of medical record data collection

Our Quality Improvement staff will contact the provider's office when we need to review or copy any medical records required for quality improvement studies. Office staff must provide access to medical records for review and copying.

Click to return to Table of Contents

Quality Management – Utilization

Twice a year, and in accordance with NCQA standards, Anthem analyzes relevant utilization data against established thresholds for each health plan to detect current utilization levels. If our findings fall outside specified target ranges and indicate potential under-utilization or over-utilization, further analysis will occur based on the recommendation of Anthem's Utilization Management committee. The follow-up analysis may include gathering the following data from specific provider and practice sites:

- Case management services needed by members
- Claims payments for covered services
- Coordination with other providers and agencies
- Focus studies
- Investigation and resolution of member and provider complaints and appeals within established time frames
- Retrospective reviews of services provided without authorization

Best practice methods

Best practice methods are Anthem's most up-to-date compilation of effective strategies for quality healthcare delivery. We share best practice methods during site visits to provider offices. Member Services and Provider Experience departments offer policies, procedures, and educational toolkits to help guide improvements. Toolkits may include examples of best practices from other offices, including:

- Resources for improving compliance with preventive health services
- *Clinical Practice Guidelines*
- Care for members with special or chronic care needs

Member satisfaction surveys

Member satisfaction with Anthem's healthcare services is measured every year through the annual member satisfaction survey. An NCQA-certified vendor conducts a survey called the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The survey is designed to measure member satisfaction with our services, including:

- Access to care
- Anthem customer service
- Provider communications
- Provider office staff performance
- Rating of Healthcare
- Coordination of care

We distribute the results of the CAHPS survey to providers. Providers should review the results, share the results with office staff and incorporate appropriate changes in their offices.

Provider satisfaction surveys

Anthem may conduct provider surveys to monitor and measure provider satisfaction with our services and identify areas for improvement. Provider participation in these surveys is highly encouraged, and your feedback is very important. We inform providers of the results and plans for improvement through provider bulletins, newsletters, meetings, or training sessions.

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

Medical Records and Facility Site Reviews

We conduct medical record and facility site reviews to determine provider:

- Compliance with standards for providing healthcare.
- Compliance with standards for storing medical records.

Click to return to Table of Contents

- Compliance with processes that maintain safety standards and practices.
- Involvement in the continuity and coordination of member care.

Please note: We perform all inspections and evaluations in such a manner as to not unduly delay work, in accordance with the Provider Agreement.

Medical record documentation standards

Anthem requires providers to maintain medical records in a manner that is current, organized and permits effective and confidential member care and quality review. Medical records must be stored and retrieved in a manner that protects patient information according to the Confidentiality of Medical Information Act, which requires the following:

- Providers of healthcare are prohibited from disclosing any individually identifiable information regarding a patient's medical history, mental and physical condition, or treatment without the patient's or legal representative's consent or specific legal authority.
- Records required through a legal instrument may be released without patient or patient representative consent.
- Providers must be familiar and in compliance with the security requirements of the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*.

Medical record requirements

At a minimum, every medical record must include the following:

- The patient’s name or identification (ID) number on each page in the record
- Personal biographical data, including home address, employer, emergency contact name and phone number, home and work phone numbers, and marital status
- Entries dated with month, day, and year
- Entries documented with the author’s identification and title, for example, handwritten signature, unique electronic identifier, or initials
- Identification of all providers participating in the member’s care
- Information on the services furnished by these providers
- List of problems, including significant illnesses, medical conditions, and psychological conditions
- Presenting complaints, diagnoses, and treatment plans, including the services to be delivered
- Physical findings relevant to the visit, including vital signs, normal and abnormal findings, and appropriate subjective and objective information
- Information on allergies and adverse reactions or a notation that the patient has no known allergies or history of adverse reactions
- Information on advance directives
- Past medical history, including serious accidents, operations, and illnesses
- Physical examinations, treatment necessary, and possible risk factors relevant to the particular treatment
- Prescribed medications, including dosages and dates of initial or refill prescriptions
- Information about the individuals to be instructed in assisting the patient
- Medical records legible, dated, and signed by the provider, physician assistant, nurse practitioner, or nurse midwife providing patient care
- Up-to-date immunization record for adults:
    - Documentation of attempts to provide immunizations (If the member refuses immunization, proof of voluntary refusal of the immunization in the form of a signed statement by the member or guardian shall be documented in the member’s medical record.)
    - Evidence of preventive screening and services, in accordance with Anthem ’s preventive health practice guidelines

Click to return to Table of Contents

- Documentation of referrals, consultations, diagnostic test results, and inpatient records (Evidence of the provider's review may include the provider's initials or signature and notation in the patient's medical record. The provider may indicate review and patient contact, follow-up treatment, instructions, return office visits, referrals, and other patient information.)
- Notations of patient appointment cancellations or no-shows and the attempts to contact the patient to reschedule
- No indication or implication that the patient was placed at inappropriate risk by a diagnostic test or therapeutic procedure
- Documentation on whether an interpreter was used in any initial or follow-up visit

Medical record security

Medical records must be secure and inaccessible to unauthorized access to prevent loss, tampering, disclosure of information, alteration, or destruction of the records. Information must be accessible only to authorized personnel within the provider's office, Anthem, or to persons authorized through a legal instrument. Records must be made available to Anthem for purposes of quality review, HEDIS and other studies.

Storage and maintenance

Active medical records should be stored in a central medical record area and must be inaccessible to unauthorized persons. Medical records are to be maintained in a manner that is current, detailed, and organized, permitting effective patient care and quality review while maintaining confidentiality. Inactive records are to remain accessible for a period of time that meets state and federal guidelines.

Availability of medical records

The medical record system must allow for prompt retrieval of each record when the member comes in for a visit or if the member requests a medical record amendment/correction. Providers must maintain members' medical records in a detailed and comprehensive manner that accomplishes the following:

- Conforms to good professional medical practice
- Facilitates an accurate system for follow-up treatment
- Permits effective, professional medical review and medical audit processes

Medical records must be legible, signed and dated, and maintained for at least seven years as required by state and federal regulations.

Providers must supply a copy of a member's medical record upon reasonable request by the member at no charge. The provider also must facilitate the transfer of the member's medical record to another provider at the member's request. Access to medical records and confidentiality must be provided in accordance with the standards mandated in *HIPAA* and all other state and federal requirements.
Providers must permit Anthem representatives to review members' medical records for the purposes of monitoring the provider's compliance with the medical record standards, capturing information for clinical studies, monitoring quality or any other reason.

Advance directives

Recognizing a person's right to dignity and privacy, our members have the right to execute an advance directive, also known as a living, will, to identify their wishes concerning healthcare services should they become incapacitated. Providers are expected to adhere to the following guidelines:

- Discuss the sensitive issues raised by advance directives with patients and their families.
- Advise members of their right to change or revoke their advance directive at any time.
- Advise members of their right to contact Member Services to request additional information about advance directives.
- Document in the member's medical record the discussion about advance directives.

Click to return to Table of Contents

- Document in the member's medical record whether or not an advance directive has been completed.
- Place a copy of a completed advance directive in the member's medical record.

Section XV: Fraud, Waste, and Abuse

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

Understanding Fraud, Waste, and Abuse

Combating fraud, waste and abuse begins with knowledge and awareness:

- **Fraud**: Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it — or any other person. This includes any act that constitutes fraud under applicable Federal or State law.
- **Waste:** Includes overusing services, or other practices that, directly or indirectly, result in excessive costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- **Abuse:** Behaviors that are inconsistent with sound financial, business, and medical practices and result in unnecessary costs and payments for services that are not medically necessary or fail to meet professionally recognized standards for healthcare. This includes any member actions that result in unnecessary costs.

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 Customer Service if something is incorrect.

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 at **833-727-2170**, Monday through Friday, 8 a.m. to 8 p.m. ET.

Reporting Fraud, Waste, and Abuse

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

You can report your concerns by:

- Visiting our **fighthealthcarefraud.com** education site; at the top of the page, select **Report it** and complete the ***Report Fraud, Waste and Abuse*** form.
- Calling Provider Experience.
- Members, providers, or individuals caring for members can call Customer Service

Any incident of fraud, waste or abuse may be reported to the SIU anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. We appreciate your time in referring suspected fraud but be advised that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.

Examples of provider fraud, waste, and abuse

Click to return to Table of Contents

The following are examples of provider fraud, waste, and abuse:

- Altering medical records
- Billing for services not provided
- Billing for medically unnecessary tests
- 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 /or 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

The following are examples of member fraud, waste, and abuse:

- Forging, altering, or selling prescriptions
- Letting someone else use a member's identification (ID) card
- Not notifying the health plan when relocating to an out-of-service area

When reporting concerns involving a member include:

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

Investigation Process

We investigate all reports of fraud, waste and abuse for all services provided under the contract. 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 in context to previously submitted claims and/or to substantiate allegations.
- **Prepayment Review**: A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.
- **Recoveries**: We recover overpayments directly from the provider. Failure of the provider to return the overpayment may result in reduced payment of future claims and/or further legal action.

Click to return to Table of Contents

If you are working with the SIU, all communication (checks, correspondence) should be sent to:

Anthem Blue Cross and Blue Shield
Special Investigations Unit
740 W Peachtree St. NW
Atlanta, Georgia 30308
Attn: investigator name, #case number

Paper medical records and 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 medical records electronically is an option if you register for an Availity Essentials account. Contact Availity Client Services at **800-AVAILITY** (**282-4548**) for more information.

About prepayment review

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

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

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

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

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

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

Acting on Investigative Findings

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

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

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

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

Member Reporting

Members should let us know if they suspect a doctor, dentist, pharmacist, other healthcare providers or another person receiving benefits is doing something wrong. Members should contact us at:
Member Services phone: **833-727-2169, TTY: 711**

Both providers and members may report fraud, waste, and abuse by completing our Fraud, Waste and Abuse Report Form online at our website: **https://www.anthem.com/oh/provider/state-federal**. To locate this form, select **Fraud, Waste, and Abuse** at the bottom of the page.

False Claims Act

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

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

Employee Education About the *False Claims Act*

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

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

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

Section XVI: Introduction to Long-Term Services and Supports (LTSS)

This chapter outlines the requirements, policies, and practices for providers delivering LTSS to members enrolled in Anthem. LTSS are designed to help members live independently in their homes and communities and avoid unnecessary institutionalization.

Next Generation MyCare Ohio's waiver program is a statewide coordinated care program for Ohioan's eligible for both Medicare and Medicaid services, who meet eligibility requirements for the MyCare Ohio Waiver. Anthem's fundamental approach is founded on person-centered principles and practices to facilitate member- and family-driven services and supports that are responsive and meaningful to evolving preferences, support needs and personal goals.

Anthem is dedicated to assisting all members in exploring service and support options to maximize community integration in alignment with their personal goals. Through this commitment, Anthem supports members to succeed in communities of their choice, and partners with providers, stakeholders, and associations.

The Next Generation MyCare Ohio waiver program focuses on improving member and provider experience, enhancing individual and population wellness, and promoting independence for individuals with complex needs. Key goals of this program are to:

- Create a personalized care experience
- Support providers in improving care
- Increase program transparency and accountability

LTSS Provider Participation Requirements

To participate in the Anthem network, LTSS providers must:

1) Enroll with the Ohio Department of Medicaid (ODM)
    - Enroll with ODM via the Medicaid Provider Portal, completing the online application.
    - If required, credentialing will occur automatically during application processing.
2) Depending on the service, become certified with the Ohio Department of Aging (ODA)
3) Contract with Anthem
    - Contracting inquires can be sent to **OHLTSSProviderInquiries@anthem.com**
    - If for any reason a provider cannot be contracted, Anthem may arrange a single-case agreement, depending on Anthem and/or ODM's discretion.
4) Waiver and Provider Compliance Requirements: Beyond enrollment, certification (if applicable) and contracting, LTSS providers must also:
    - Maintain an active, valid Medicaid provider agreement
    - Comply with relevant Ohio Administrative Code (OAC) requirements, including:
        - Enrollment standards (OAC 5160-45-04)
        - Criminal record checks (OAC 5160-45-07, 5160-45-11)
        - Incident reporting and provider oversight (OAC 5160-44 and 5160-45)
    - Ensure providers and their staff:
        - Are at leaset 18 years old, and literate in English to understand and follow requirements
        - Communicate professionally and respectfully with individuals
        - Respect individual person-centered care plans and safeguard health and welfare
    - Provide backup plan coordination if unable to deliver services, notifying case managers in advance or immediately in emergencies.
    - Complete ODM-mandated provider training
        - Within 90 days after Medicaid enrollment
        - Participate in ongoing trainings as required
    - Complete Anthem-mandated provider training

Click to return to Table of Contents

    - LTSS provider onboarding within 30 days of contracting
    - Participate in ongoing trainings as required
- Stay compliant with federal and state laws, including HIPAA and the HCBS Settings Final Rule.

Self-Directed providers must:

- Respect the member's authority to select and direct their workers.
- Coordinate with the Waiver Service Coordinator and Financial Management Service (FMS) as needed
- Follow all Mediciad requirements, including background checks, incident reporting, and training standards
- Ensure services are delivered according to the member's approved person-centered care plan

Independent (non-agency) providers must:

- Be enrolled and approved as a Medicaid provider through ODM.
- Meet all applicable requirements under Ohio Administrative Code (OAC) Chapters 5160-44 and 5160-45
- Maintain an active Medicaid provider agreement.
- Complete required pre-service and ongoing training.
- Pass criminal background checks and other compliance screenings as required by ODM.
- Adhere to all applicable federal and state Medicaid laws, rules and policies.
- Respect member rights and provide services in a manner that supports independence, dignity, and choice.
- Maintain professional communication with members, waiver service coordinators, and Anthem.
- Participate in quality oversight and compliance activities conducted by ODM and/or Anthem.

Long-Term Services and Supports-Home and Community Based Services (HCBS) Covered Benefits

NextGeneration MyCare covered benefits include the long-term services and supports (LTSS) listed below:

Benefits	Next Generation MyCare
Adult day health services	Covered
Alternative meal services	Covered
Assisted living services	Covered
Choice home care attendant services	Covered
Community integration services	Covered
Community transition services	Covered
Enhanced community living services	Covered
Homemaker services	Covered
Home care attendant services	Covered
Home delivered meal services	Covered
Home maintenance and chore services	Covered
Home medical equipment and supplemental adaptive and assistive devices	Covered
Home modification services	Covered
Nutrition consultation services	Covered
Out-of-home respite services	Covered
Personal care aide services	Covered
Personal emergency response services	Covered
Social work counseling services	Covered

Click to return to Table of Contents

Benefits	Next Generation MyCare
Waiver nursing services	Covered
Waiver transportation services	Covered
Structured family caregiving services	Covered

All covered services are contingent upon assessed need, authorization, and benefit coverage at the time of service.

Self-Directed Covered Benefits

Self-direction is a service delivery option available u nder the Next Generation MyCare Ohio waiver program. It allows members to take a more active role in managing their Long-Term Services and Supports. Instead of relying only on an agency to provide workers, the member (or their chosen representative) can recruit, hire, and supervise their own direct care workers. Key features of self-direction include:

- Member Choice and Control: Members decide who provides their care, when services are delivered, and how tasks are carried out.
- Direct Care Workers: Members may hire family, friends, or other qualified individuals to provide care, as long as they meet Medicaid and Next Generation MyCare program requirements.
- Individual Budget: Members receive an approved service budget that can be used flexibly within program rules to meet their assessed needs.
- Employer Responsibiltiies: The member (or representative) takes on certain responsibilities of an employer, such as scheduling, supervising, and verifying hours worked.
- Financial Management Services (FMS): To support members with employer tasks, a FMS agency helps with payroll, taxes, and other administrative tasks.
- Coordination Support: The MyCare Ohio Care Coordinator works with the member to develop and monitor the person-centered care plan and ensure health, safety, and quality of care.

All members are offered the choice to self-direct eligible HCBS. Members are permitted to use self-direction in combination with agency services, as long as services are not provided at the same time.

Benefits	Next Generation MyCare
Alternative meals service	Covered
Waiver nursing services	Covered
Personal Care	Covered
Choice home care attendant service	Covered
Self-directed goods and services	Covered
Home modifications	Covered
Home medical equipment and supplemental additive and assistive device services	Covered
Home maintenance and chore	Covered
Home care attendant	Covered

Independent Provider Covered Benefits

An independent LTSS provider is an individual who is self-employed, rather than being employed by an agency, and provides waiver services directly to members. Independent providers do not work under an agency and are solely responsible for delivering and documenting services in accordance with Medicaid rules.

Click to return to Table of Contents

An independent provider may deliver on the service for which they are approved and credentialed by ODM. Certain services, such as skilled nursing or licensed therapies, must be provided by licensed or agency providers and are not available through independent providers.

Benefits	Next Generation MyCare
Personal Care	Covered
Waiver Nursing	Covered
Home Care Attendant	Covered
State Plan Private Duty Nursing (PDN)	Covered

All services must be included in the member's person-centered care plan and authorized by Anthem.

Independent providers must:

- Deliver services according to the scope, frequency, and duration specified in the service plan.
- Maintain service documentation that meets ODM standards.
- Notify the member and waiver service coordinator promptly of any changes in service availability.
- Follow incident reporting procedures to protect health and safety.

Independent provider may not:

- Deliver services outside the scope of their approved provider type.
- Authorize or self-approve their own services.
- Provide services not included in the member's plan.
- Subcontract or hire others to provide services on their behalf.

Detailed descriptions of covered services, limitations, and authorization requirements are outlined in Appendix A.

Long-Term Custodial Care

Long-term custodial care refers to ongoing assistance provided to members who have chronic illness, disability, or other conditions that limit their ability to perform activities of daily living (ADLs) independently. Custodial care is non-skilled, supportive care that helps members maintain their health and safety. Custodial care may include:

- Personal care support such as assistance with bathing, dressing, eating, toileting, and mobility.
- Homemaker services such as light housekeeping, meal preparation, and laundry to support a safe home environment.
- Supervision and cueing for member with cognitive impairments who need reminders or oversight to remain safe.
- Companionship and monitoring to reduce isolation and ensure wellbeing.

Custodial care differs from skilled care. It does not include skilled medical services such as injections, wound care or therapy. Rather, it focuses on day-to-day support rather than medical treatment. Skilled care must be provided by licensed professionals, whereas custodial care may be provided by trained aides, homemakers or independent providers.

Nursing Facility Eligibility

Nursing Facility Level of Care (NFLOC) is determined based on state law and administrative rule. The population for this program is individuals 65 and older who are functionally eligible for Medicaid, on the basis of age, blindness, or disability and have limited income and resources. (Frail Elderly or FE Waiver)

Click to return to Table of Contents

Nursing Facility — Pre-Admission Screening and Resident Review

Anthem follows state policy found in the Client Assessment, Referral and Evaluation (CARE) program for Level of Care (LOC) Level I and Level II and Pre-Admission Screening Resident Review (PASRR) requirements. Level of Care and PASRR determinations are conducted by assessors through the local Area Agencies on Aging (AAA). For more information on the PASRR form, please see the form **here**.

Before the nursing facility can be reimbursed for the care provided, the nursing facility or other appropriate entity must request a Pre-Admission Screening Resident Review (PASRR) for nursing facility placement. The State or Assessor must then approve the PASRR request and designate the appropriate level of care in the State's system. Anthem coordinates care for its members that are transitioning into long-term care by working with the facility to ensure timely submission of the request for a PASRR.

Anthem Referral Process Providers are selected during the member assessment process completed by Anthem. Petitioning members with the expectation of being selected as the service provider or petitioning existing members who receive Anthem services to change their providers is prohibited. Additionally, communicating with hospitals, discharge planners or other institutions for the purposes of soliciting potential Anthem members is prohibited. Requests from a provider to be added as a service provider for any member will prompt the assigned Anthem coordinator to outreach to the member for clarification of the member preference. Updates to add service providers are solely driven by members and their designated representatives.

Care Coordination and Person-Centered Planning

Anthem Care Coordination

Each member in the Anthem Care Coordination program will have an assigned Care Coordinator who will facilitate the coordination of physical and behavioral services and supports that are documented and tracked in an Individualized Plan of Service or Person-Centered Care Plan (PCCP). The care coordinators are the central, primary points of contact to ensure consistent ongoing communication between the member, providers, caretakers, and all other participants of the Interdisciplinary team (IDT) The care coordinator's primary role includes:

- Supporting members with timely and coordinated access to an array of providers, covered services, and supports.
- Monitoring for SDOH support needs and connecting individuals to community-based services.
- Using a Strengths based, person-centered, and holistic approach at all times to ensure each member remains in control of their care planning and their individual needs are supported in a way that aligns with how they want to be supported.
- Representation and advocacy with agencies, providers, and facilities on behalf of the member.
- Working with Medicare payers, Medicare Advantage plans, and Medicare providers as appropriate to coordinate the care and benefits of members who are also eligible for Medicare.
- Members who are eligible for HCBS waivers will have an assigned service coordinator to facilitate the coordination of HCBS services which are captured in a PCCP. Waiver Service Coordination is often offered through partnership with the local Agency Area on Aging (AAA). Alternatively, members may opt to receive it through Anthem Care Coordination program. The responsibility of the WSC in partnership with the CC include: Assessing for and communicating information about member-specific support needs and preferences to facilitate effective referral matches.
- Facilitating provider selection by providing the member with all available options to support service delivery.
- Connecting the member to community-based resources to address all identified SDOH needs.
- Coordinating with WSC in the creation of Service Plans that align with preferences and eligible benefits

- Actively securing the necessary authorizations for the services that are the responsibility of the MCOP, and coordinating with the Waiver Service Coordinator and providers to ensure the member's timely access to the services identified in the person-centered care plan.
- Engaging with all LTSS/HCBS providers and community-based providers identified to ensure they fully understand their role in supporting the member to achieve their desired outcomes as identified in the Person-Centered Care Plan.
- Following up with the member to ensure all service delivery is in place and is being conducted in alignment with the Person-Centered Care Plan to include both LTSS providers and community-based supports.
- Engaging with providers in the development and ongoing revisions of Care and Service Plans, and participation in the ICT.
- Keeping providers informed about the status of Care and Service Plan outcomes and changes.
- Facilitating resolution when a member/provider grievance occurs.

It is the responsibility of every provider to notify the care coordinator if any of these scenarios are identified by the provider:

- Change in member condition, environment, or availability of caregiver supports
- An inpatient hospitalization or ER occurrence
- Suspected abuse, neglect, or exploitation
- Needed modification to a goal or support strategy or barriers to achieve the member's desired outcome
- A change in the member's preferences about the existing Care or Service Plan
- Any other situation that would necessitate a Care or Service Plan revision

We will provide training to all LTSS/HCBS providers regarding the value and available modes of communication and remind them that the member's identification card indicates if a member is enrolled in Anthem. Through the LTSS/HCBS provider training, providers will also be educated on how to contact the care and service coordinators, including contacting Member Services.

Person-Centered Practices

All providers are expected to conduct all member interactions using a person-centered approach and ensure member choice and self-determination are supported at all times. For successful person-centered planning to occur, the provider must have a clear understanding and shared appreciation of what is important to and for each member and how they want to be supported.

Using person-centered language is an important aspect of person-centered practices as it recognizes the impact of language on thoughts and actions. It ensures language does not diminish the uniqueness and intrinsic value of each individual and allows a full range of thoughts, feelings, and experiences to be communicated. It is important to emphasize cultural preferences and communication style when training a direct support professional, so they can best support the individual.

The HCBS Settings Rule supports enhanced quality in HCBS programs that is central to an effective and meaningful person-centered planning process. A rights-based, person-centered planning process is a means to ensure LTSS consumers receive effective and robust person-centered care that:

- Is integrated in and supports full access of individuals to the greater community.
- Is selected by the individual from among setting options based on the individual's needs, preferences, and for residential settings, resources available for room and board.
- Optimizes individual initiative, autonomy, and independence making life choices.
- Facilitates individual choice regarding services and supports and who provides them.

Click to return to Table of Contents

- Supports a life of purpose and meaning.

Person Centered Care Plan

Anthem uses Person Centered Care Plans and Waiver Service Plans in accordance with the minimum requirements as defined by the State, compliant with NCQA and HCBS Settings Rule standards, and inclusive of the Anthem Best Practice model. Anthem care coordinators support each member with facilitating the process to develop a /Person Centered Care Plan (PCCP) using a person-centered planning approach to document the member's strengths, support needs, goals, desired outcomes, and preferences of how each member wants to be supported through a combination of paid, community-based, and natural supports. The person-centered planning process is always directed by the member and may include representatives of the member's choosing to assist with decision-making and to participate in the care planning process. If the member has a guardian or conservator, the member shall lead the planning process to the maximum extent possible, and the guardian or conservator shall have a participatory role as needed and defined by the member, except as explicitly defined under State law and the order of guardianship or conservatorship. Any decisions made on the member's behalf should be made using principles of substituted judgment and supported decision-making. This planning process, and the resulting PCCPs, will assist the member in achieving a personally defined lifestyle and outcomes in the most integrated community setting appropriate, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health, welfare, and personal growth. HCBS services will be authorized, provided, and reimbursed only as specified in the Person-Centered Care Plan.

For Members Residing in a Nursing Facility

For members in a nursing facility, the member's care coordinator may:

- Defer to the Service Plan developed by the nursing facility for service delivery in lieu of creating an additional Service Plan if the existing plan is sufficient to address all of the member's support needs.
- Supplement the Service Plan as necessary with the development and implementation of targeted strategies to improve health, functional ability, quality of life outcomes (for example, related to Condition Care services or pharmacy management), or to increase and/or maintain functional abilities.
- Facilitate resolution of any discrepancies between the NF plan of care and Anthem Person Centered Care Plan (PCCP) by communicating directly with the NF, member, and other Interdisciplinary Care Team (ICT) members as appropriate ensuring all plans of care are updated to be aligned.
- Participate in care rounds.
- Have regular ongoing contact with the member and their assigned representatives where applicable to monitor the progress of the NF plan of care, PCCP, as well as identification of any new or escalated issues.
- Perform an ongoing assessment of the member's desire to transition to community and the supports needed to do so.
- Offer comprehensive transition support upon a member's decision to transition back to the community or to a less restrictive environment that includes identification and coordination of all formal and community-based supports needed to support a safe transition. Coordination with the transition IDT will include the NF and HCBS providers to ensure continuity of care throughout the transition process.

Care coordinators will participate in the nursing facility's care planning process and advocate for the member. All members will still receive a PCCP with support from their care coordinator.

The member's care coordinator as well as the Transition Support team are responsible for coordinating the member's physical health, behavioral health, and LTSS needs. This will include coordinating with the nursing facility as necessary to facilitate access to physical health and/or behavioral health services needed by the member and to help ensure the proper management of the member's acute and/or chronic physical health or behavioral health conditions, including services covered by Anthem that are beyond the scope of the nursing facility services benefit.

Click to return to Table of Contents

For Members in Community-Based Settings

For members in community-based settings, the care coordinator will coordinate and facilitate a care/service planning team that includes the member, those identified by the member who act as natural supports, providers, other support coordinators, and community-based partners. The care coordinator will include or seek input from others as authorized by the member to assist with needs assessment and care planning activities as needed.

Some of the activities the care coordinator conducts as a part of Person-Centered Care Plan development include:

- Gathering pertinent demographic information regarding the member, including the name and contact information of any representative and a list of other persons authorized by the member to have access to healthcare (including long-term-care-related information) and assisting with assessment, planning and/or implementation of healthcare (including long term care related services and supports).
- Determining care, including specific tasks and functions that will be performed by family members and other caregivers.
- Determining home health, private duty nursing, and LTSS/HCBS services the member will receive from other payer sources including the payer of such services.
- Determining home health and private duty nursing services that will be authorized by Healthy Blue.

HCBS services that will be authorized by Anthem care coordinators include:

- The amount, frequency, duration, codes, and scope (tasks and functions to be performed) of each service to be provided.
- The schedule of when such care is needed.

The Person-Centered Care Plan will include the following elements:

- Member's name and demographics
- Date, location, and who was involved in the planning meeting
- Date of last Level of Care Assessment
- Description of medical equipment used or needed by the member (if applicable)
- Description of each member's communication style as well as any special communication needs, including interpreters or special devices
- Description of goals, objectives, and desired health; and the functional and quality of life outcomes for the member
- Description of other services that will be provided to the member, including:
  - Covered physical and behavioral health services that will be provided by Anthem to help the member maintain or improve their physical or behavioral health status, or functional abilities and maximize independence
  - Other social support services and assistance needed in order to ensure the member's health, safety and welfare and, as applicable, to delay or prevent the need for more expensive institutional placement
  - Any noncovered services including services provided by other community resources, including plans to link the member to financial assistance programs, including housing, utilities and food as needed
- Relevant information from the person's treatment plan for any member receiving behavioral health services that is needed by a LTSS provider, caregiver, or the care coordinator to ensure appropriate delivery of services or coordination of services

Click to return to Table of Contents

- Review and acknowledgment of key member rights and informed choices
- Frequency of planned care coordinator contacts needed, which will include consideration of the person's member needs and circumstances
- Additional information for members who elect self-direction of HCBS, including whether the member requires a representative to participate in consumer direction and the specific services that will be self-directed
- Any steps the member and/or representative should take in the event of an emergency that differ from the standard emergency protocol
- A disaster preparedness plan specific to the member
- All key signatures for accepting or declining of the PCCP.

The member's care coordinator will provide a copy of the member's completed Individualized Person-Centered Care Plan including any updates, to the member, the member's representative, the member's providers authorized to deliver care to the member, and other IDT members as applicable. A member can elect not to share their Person-Centered Care Plan When this occurs, the care coordinator will ensure that providers who do not receive a copy are informed in writing of all relevant information needed to ensure the provision of quality care for the member and to help ensure the member's health, safety, and welfare, including the tasks and functions to be performed.

Shortly after completing a reassessment of a member's needs, the member's care coordinator/care coordination team will update the member's plan of care as appropriate and authorize and initiate HCBS in the updated Person-Centered Care Plan.

Member Enrollment
For individuals who come into the program with no current Medicaid coverage, MCO assignment will be effective on the date of eligibility approval. Medicaid coverage may be effective up to three months retroactively from their application date.

Individuals transitioning from an existing Medicaid Managed Care program or FFS, MCO assignment will be effective the first day of the month following the notice of change in eligibility.

Plan selection can be made by calling the State's Managed Care Enrollment Center within 60 days of coverage start. The State's Managed Care Enrollment Center will be responsible for providing choice counseling to the member. If a member does not select a plan there will be an assignment process in place directed by the State. Plan assignment will favor plan alignment between Medicare and Medicaid to the greatest extent allowable. Other factors may be considered such as the residential provider of the member (if applicable).

In accordance with 42 CFR 438.3(q)(5); 42 CFR 438.56(c)(1); and 42 CFR 438.56(c)(2)(i)-(iii), members have the right to disenroll from the Contractor:

- For just cause at any time.
- Without cause within 90 days after initial enrollment or during the 90 days following notification of enrollment, whichever is later.
- Without cause at least once every 12 months.
- Without cause when Anthem repeatedly fails to meet substantive requirements in sections 1903(m) or section 1932(e)(2)(B)(ii) of the Social Security Act and 42 CFR 438.56(b)-(d).
- Without cause upon reenrollment if a temporary loss of enrollment has caused the enrollee to miss the annual disenrollment period.

- During a plan selection period which will be aligned with the Medicare open enrollment window to be effective the following calendar year.

Home and Community Based Service Descriptions
Members eligible for home- and community-based services (HCBS) may use different services to meet their support needs, in combination with informal caregiver supports and other community resources. Through the development of the Person-Centered Care Plan (PCCP), members and their care and service coordinators along with input from others chosen by the member will determine the best supports to meet the person's needs and support achievement of self-identified quality of life goals.

Home and Community-Based Services Settings Rule Compliance
HCBS:

- Is integrated in and supports access to the greater community.
- Provides opportunities to seek employment and work in competitive integrated settings, engage in community life and control personal resources.
- Ensures the person receives services in the community to the same degree of access as individuals not receiving Medicaid home- and community-based services.
- Is selected by the person among setting options including non-disability-specific settings and an option for a private unit in a residential setting.

The intent of the HCBS final rule is to ensure members receiving long-term services and supports through HCBS programs under the 1915(c), 1915(i), and 1915(k) Medicaid authorities have full access to benefits of community living and an opportunity to receive services in the most integrated setting appropriate and enhance the quality of HCBS and provide protections to participants.

HCBS Final Settings Rule Compliance is assessed by the Ohio Department of Aging (ODA) via the HCBS Compliance Portal. All settings supporting HCBS participants must demonstrate compliance with 42 C.F.R. § 441.301(c) to be determined compliant and receive a current HCBS Compliance Certificate. Anthem will verify compliance with the HCBS Settings Rule as a part of the HCBS provider qualification audit. Acceptable documentation includes:

1. A current HCBS Compliance Certificate, or
2. A signed Heightened Scrutiny Attestation

Additionally, Anthem provider relations representatives will complete annual provider visits that include evaluating physical location, policies, procedures, and other written documentation, employee training, and sampling employee files. In addition, we will conduct ongoing provider education training and technical assistance on the HCBS Settings Rule as deemed necessary.

The Anthem Settings Compliance Committee will review referrals provided from the care/service coordinator leadership and as part of their review will complete the following:

- Review any proposed or emergency right restrictions and restraints included and not included in a Behavioral Support Plan (BSP), PCCP for potential human rights violations and ensuring informed consent of any restriction.
- Provide input for any modifications to member's rights when the member resides in a provider owned or controlled residential setting prior to modification being included in member's person-centered support plan.
- Review potential violations to HCBS Settings Rules in instances in which a member is living in an unlicensed setting or licensed setting other than those covered in benefits for Anthem members that

may be in violation of HCBS Settings Rules and make recommendations for coming into compliance with HCBS Settings rules.
- Review and make recommendations regarding complaints received pertaining to potential human rights violations.
- Ensure proposed restriction is the least restrictive viable alternative and is not excessive.
- Ensure proposed restriction is not for staff convenience.

Service Delivery Expectations

Anthem's Next Generation MyCare Ohio LTSS providers play a critical role in helping members lives safely and independently in their homes and communities. Providers are expected to deliver services in accordance with the member's person-centered care plan, established program rules, and all applicable state and federal requirements. Service delivery must be consistent, timely, and aligned with the members' assessed needs and preferences. Providers are responsible for maintaining professional standards, protecting the health and safety of members, and ensuring that all documentation, communication, and compliance obligations are met.
Providers must meet the following expectations:

- Services must be delivered in accordance with the approved person-centered care plan.
- Providers must use Electronic Visit Verification (EVV) when required by federal regulations, ODM and Anthem.
- Documentation must be accurate, completed and timely.
- Critical incidents (including suspected abuse, neglect, or exploitation) must be reported to Anthem and appropriate authorities within required timeframes.
- Providers are expected to meet service initiation timeliness standards and quality benchmarks established by Anthem.
- Align with HCBS Settings Rule.

Electronic Visit Verification System

The 21st Century Cures Act (Cures Act), signed into law on December 13, 2016, requires states to implement an Electronic Visit Verification (EVV) system for Personal Care Services and Home Health Care Services. The primary purpose of the EVV system is to enable Managed Care Entities (MCEs) to validate all service claim lines against electronically verified visit data collected in the Sandata EVV Aggregator, ensuring compliance with the 21st Century Cures Act. This federal mandate requires the verification of specific elements of care, including the service type, care recipient, service date, delivery location, care provider, and the service duration.
Electronic Visit Verification PCS and HHCS visit codes can be found at.
https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Providers/EVV/Providers/ODM_EVV_Covered_Programs_and_Services.pdf

Information about Sandata system can be found at **Electronic Visit Verification | Medicaid https://medicaid.ohio.gov/resources-for-providers/special-programs-and-initiatives/electronic-visit-verification**. Anthem will use the Ohio Sandata system to validate Sandata, please do so at **https://sandata.zendesk.com/hc/en-us/sections/8009092910867-Ohio-OH-ODM**.

Providers offering personal care and home health services are required to electronically report six essential items to ensure that individuals receive the care they need. The six items are:

- Type of service performed
- Individual receiving the service
- Date of the service
- Location where the service was delivered
- Individual providing the service

Click to return to Table of Contents

- Time the service begins and ends

The primary methods of capturing visit records are:
- Sandata application (smartphone application)
- Telephonic Visit Verification (using a member's landline telephone)

Anthem encourages the use of mobile or telephonic visit verification to capture visit information. In the event neither method is available manual visit entry is available to document visit information.

Contracted providers must have at least two staff fully trained on the EVV system that can train others on using the device in the member's home. An additional expectation is that at least one staff person with the contracted provider is dedicated to monitoring activity and supporting the proper use of visit verification, including monitoring use of manual visit entry.

Billing and Claims for LTSS

Claim Submission Process

Claims must be submitted by providers electronically through the Ohio Department of Medicaid (ODM)'s Fiscal Intermediary (FI) via an Electronic Data Interchange (EDI) trading partner. If you do not have a trading partner and are submitting direct data entry claims through Availity Essentials or Care Central, the claim will be sent to the FI with no action needed. If the submitted claim passes the FI's SNIP level edits, the claim will be passed to us for adjudication.

- **Availity Essentials**: We use Availity Essentials as our secure provider portal:
  - **Website: https://Availity.com**
  - **EDI Payer ID:** [0022147]
  - **Features:**
    - Secure access to manage daily transactions with payers.
    - No special software is required.
    - Check eligibility, submit claims, and track claims status.
  - For questions, contact Availity client services at **8002824548** between 8 a.m. and 8 p.m. ET, Monday through Friday.
- **Care Central:** This application is available through Availity Essentials and was designed specifically for HCBS providers to simply and streamline claims processes:
  - **Website: https://Availity.com** > *Payer Space* > Anthem Blue Cross and Blue Shield > *Applications* > *Care Central*
  - **Features:**
    - Tailored for LTSS providers, reducing claim fields to essentials for the service type.
    - Provides real time visibility into claim status.
  - For questions, contact Availity client services or your LTSS provider relationship management representative directly.
- **Clearinghouse:** Acts as an intermediary to electronically transmit claims data. This may involve fees charged to providers for submission services.

State of Ohio EVV Application should be used for the review and submittal of original claims for EVV Covered HCBS-PCS and Home Health Care Services (HHCS). As of January 22, 2025, this is the only approved method for original claims submittals for EVV Covered HCBS-PCS and Home Health Care Services (HHCS).

Payment of Claims

Once we receive a claim from the Fiscal Intermediary, Anthem takes the following steps:

- Anthem's processing systems analyze and validate the claim for member eligibility, covered services, and proper formatting.
- Anthem's processing systems validate billing, rendering, and referring provider information against Anthem and ODM files.
- Anthem's processing systems validate against processing rules such as a requirement for referral, prior authorization, or NDC and McKesson ClaimsXten Correct Coding rules.
- Medical review is performed, as necessary.
- If no payment is warranted, Anthem sends a claims remittance advice to the provider with the specific claims processing information.
- Anthem systems reference Groupers, Pricers, and Fee Schedules based on the type of claim to determine the pricing.

Monitoring Submitted Claims

Submitted claims can be monitored within Availity Essentials by navigating to Claim & Payments > Claim Status. Additionally, LTSS/HCBS providers can further view the status of their claims by navigating to the Care Central application with Payer Spaces. Monitoring claims within Care Central can be completed in the Claims tab. It is here where providers can see the status of their claims along with other cumulative information about their claim history.

Additional information on LTSS billing guidance, please refer to Appendix A: Billing and Claims for LTSS.

Compliance and Oversight

HCBS (Home and Community-Based Services) provider oversight with the auditing team covers several key aspects of the process. Audits are conducted to ensure compliance with state, federal, and NCQA requirements, verifying that providers meet necessary qualifications, including staff training and background checks. They assess whether services are being delivered according to authorized plans regarding type, scope, amount, duration, and frequency. The process also focuses on detecting fraud and abuse, monitoring the quality of care in long-term services, ensuring financial accountability, and maintaining transparent and accurate claims. Additionally, the audits aim to align service plans with individuals' needs and goals, while collaborating with managed care organizations to reduce providers' administrative burdens. For agency providers, audits occur at least biennially, with corrective action plans required for any quality concerns. The auditing process includes sample selection, provider notification, a comprehensive review, an exit conference, and final reporting to key stakeholders. If corrective actions are needed, providers have 30 days to respond, with follow-ups to review and adjust accordingly.

Oversight activities may include:

- On-site or virtual reviews
- Record audits
- Member and caregiver feedback surveys
- Corrective action plans when deficiencies are identified

Member Rights and Safeguards

Member receiving LTSS have the right to:

- Choose from a network or qualified providers
- Receive service in the most integrated, community-based setting appropriate to their needs
- Participate fully in developing their person-centered care plan
- File a grievance or appeal if dissatisfied with a service or decision
- Be free from abuse, neglect, exploitation, and retaliation

Click to return to Table of Contents

Providers are responsible for protecting these rights and reporting any suspected violations immediately.

Resources and Contacts

LTSS Provider Relations Team

Anthem's Long-Term Services and Supports dedicated Provider Relations Team is responsible for fostering and maintaining strong partnerships with provider who deliver essential services participating in the Next Generation MyCare Ohio waiver programs. The team serves as a primary point of contact for providers, offering support and guidance to ensure they meet regulatory and contractual requirements.

LTSS providers are assigned a local and dedicated provider relations representative and will have access to other LTSS-dedicated resources, including a Provider Educator and Workforce Development Manager. This team works hand-in-hand with providers through onboarding, addressing provider concerns and inquiries, facilitating training sessions, disseminating important updates and best practices, and assisting with claims and billing processes.

To contact a member of the LTSS Provider Relations team, visit **https://www.anthem.com/oh/provider/state-federal** -->Patient Care-->Long Term Services and Supports and select **LTSS Provider Relations Map** to identify your dedicated representative or email us directly at **OHLTSSProviderRelations@anthem.com**.

Appendix A: Billing and Claims for LTSS

This appendix provides detailed billing requirements and resources for LTSS providers participating with Anthem, as a part of the Next Generation MyCare Ohio program. It is designed as a reference tool to ensure accurate, timely, and compliant claims submission.

General Billing Requirements

For detailed information related to the MyCare Ohio wavier: Covered services and providers, please see Rule 5160-58-04 linked here: **Rule 5160-58-04 - Ohio Administrative Code | Ohio Laws**.

All LTSS services must be:

- Authorized in the member's person-centered care plan (PCCP).
- Delivered by a qualified and ODM enrolled provider.
- Documented according to ODM and Anthem standards as noted in OAC 5160-58-04.

LTSS claims must reflect only the services which are delivered to the member. Providers are responsible for maintaining documentation for any audits or compliance reviews.

LTSS claims are subject to timely filing requirements. Providers have 365 days from the date of service file a claim, including any timely filing exceptions, in accordance with Ohio Administrative Code (OAC) rule 5160-1-19

Provider claim disputes are any provider inquiries, complaints, appeals, or requests for reconsiderations ranging from general questions about a claim to a provider disagreeing with a claim denial. Claim disputes are required to be submitted within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later.

We have several options to file claim payment disputes:

- Disputes can be submitted through the provider website: **https://providers.anthem.com/oh** (Select Login or Register to access the secure site.). Through Availity Essentials, you can upload supporting documentation and receive immediate acknowledgement of your submission. Locate your claim using Claim Status and select the Dispute button to initiate then select "Go To Request" to complete the dispute request. The dispute can be tracked on the Appeals dashboard.

- **Verbally** (for reconsiderations and claim payment appeals): Call Provider Services at **833-727-2170** (Monday to Friday, 8 a.m. to 8 p.m. ET). If you need to include supporting documentation (in other words, EOB, Consent Form, Medical Records, etc.) please do not use this option.
- **Written** (for reconsiderations and claim payment appeals): Mail all required and supporting documentation to:

  Anthem Blue Cross and Blue Shield
  Payment Dispute Unit
  P.O. Box 62500
  Virginia Beach, VA 23466

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 number or TIN
- The member's name and their Anthem ID number
- A listing of disputed claims including the Anthem claim number and the date(s) of service(s)
- All supporting statements and documentation

Providers submitting claims for LTSS must ensure that they include appropriate diagnosis codes as required by ODM and Anthem.

LTSS-Specific Billing Guidelines

- HCBS billing must align with approved service plans.
  - Waiver services billed per authorized units or daily rates.
  - Multiple services on the same day must be billed separately with correct modifiers.
  - EVV compliance is required; visits must match claim submission details.
  - Non-authorized services will not be reimbursed unless retro-authorization is approved.

Covered LTSS Services with Billing Details

1. Adult Day Health Services
   i) A regularly scheduled service offered at an adult day center in a non-institutional, community-based setting, which includes activities outlined in an individual's person-centered service plan. Adult Day Services (ADS) feature recreational and educational programs that support health and independence goals. The service includes one or two meals per day and may also provide health status monitoring, skilled therapy services, and transportation to and from the center.
   ii) Provider Qualifications: **Rule 173-39-02.1 - Ohio Administrative Code | Ohio Laws**
   iii) Authorization Required: Yes
   iv) Billing Guidance:
      (1) S5101 and S5102Code/Modifiers: UA, UAU1, UAU2, UAU3 billing and limits: per half day unit is less than 4 hours of ADS per day, one day unit is four to eight hours of ADS per day, 15 minute unit is each 15 minutes period of time over 8 hours up to a maximum of 12 hours of ADS per day
      (2) EVV Required: No

2. Adult Day Services (ADS) Transportation
   i) A unit of Adult Day Services (ADS) transportation can be a round trip, a one-way trip, or a distance measured in miles. The cost is determined by the case manager's calculation of the distance between the individual's home and the center, multiplied by the established ADS mileage rate. If a provider transports multiple enrolled individuals from the same household to

the same destination in the same vehicle, the payment rate for that trip is set at seventy-five percent of the per-unit rate.

ii) Provider Qualifications: **Rule 173-39-02.1 - Ohio Administrative Code | Ohio Laws**

iii) Authorization Required: Yes

iv) Billing Guidance:

(1) A0080, T2003, and T2025 Code/Modifiers: UA, UAU2, UAU5, billing and limits: 1 unit = 1 mile, 1 trip, or 1 round trip

(2) EVV Required: No

3. Alternative Meal Services

i) A participant-directed service designed to maintain and individual's health by allowing them to obtain up to two meals per day from non-traditional sources, such as restaurants, rather than from an adult-day center.

ii) Provider Qualifications: **Rule 173-39-02.2 - Ohio Administrative Code | Ohio Laws**

iii) Authorization Required: Yes

iv) Billing Guidance:

(1) S5170 Code/Modifiers: UBU3, billing unit=1 meal, limits

(2) EVV Required: No

4. Assisted Living Services

i) Encompasses both basic services and memory care aimed at promoting aging in a RCF by enhancing an individual's independence, choice, and privacy.

ii) Provider Qualifications: Rule 173-39-02.16 - Ohio Administrative Code | Ohio Laws

iii) Authorization Required: Yes

iv) Billing Guidance:

(1) T2031 Code/Modifiers: U1, U2, U3, billing unit=1 day, limits

(2) EVV Required: No

5. Choices Home Care Attendant Services

i) A supportive service designed to meet the needs of individuals with impaired physical or cognitive functioning by providing various activities, including:

1) Personal Assistance
2) ADLs and IADLs Support
3) Homemaker Activities
4) Escort and Transportation Services
5) Errands
6) Home Maintenance and Chores

ii) Provider Qualifications: **Rule 173-39-02.4 - Ohio Administrative Code | Ohio Laws**

iii) Authorization Required: Yes

iv) Billing Guidance:

(1) T2025 Code/Modifiers: UBU2, billing unit=15 minutes, limits

(2) EVV Required: Yes

6. Community Integration Services

i) A service that includes independent living assistance and community support coaching activities is essential for empowering an individual to live independently. It ensures access to, choice of, and opportunities to participate in a comprehensive range of community activities.

ii) Provider Qualifications: **Rule 173-39-02.15 - Ohio Administrative Code | Ohio Laws**

iii) Authorization Required: Yes

iv) Billing Guidance:

(1) S5135 Code/Modifiers, billing unit=15 minutes, limits
(2) EVV Required: No

7. Community Transition Services
   i) A service that covers non-recurring start-up living expenses for individuals moving from an institutional setting to a home and community-based services setting.
   ii) Provider Qualifications: **Rule 173-39-02.17 - Ohio Administrative Code | Ohio Laws**
   iii) Authorization Required: Yes
   iv) Billing Guidance:
      (1) T2038 Code/Modifiers: UA, billing unit=1 job, limits: $2000 per individual per enrollment
      (2) EVV Required: No

8. Enhanced Community Living Services
   i) A service designed to support aging in place within multi-family affordable housing. It provides access to on-site, individually tailored, health-related, and supportive interventions for individuals with functional deficits due to one or more chronic health conditions.
   ii) Provider Qualifications: **Rule 173-39-02.20 - Ohio Administrative Code | Ohio Laws**
   iii) Authorization Required: Yes
   iv) Billing Guidance:
      (1) T2025 Code/Modifiers: UA and U1, billing unit= 15 minutes, limits
      (2) EVV Required: Yes

9. Homemaker
   i) A service that helps individuals achieve and maintain clean, safe, and healthy living environments, manage personal appointments, and handle day-to-day household activities to sustain their current living arrangements. When authorized in the person-centered services plan, homemaker activities include:
      (1) Assisting with meal planning.
      (2) Meal preparation, grocery planning, and help with shopping and other errands.
      (3) Laundry tasks such as washing, drying, folding, ironing, and putting away laundry at the individual's home, or using a laundromat if necessary.
      (4) House cleaning tasks, including dusting, sweeping, vacuuming, mopping floors, kitchen care (such as dishes, appliances, counters), bathroom care, emptying and cleaning bedside commodes, changing bed linens, washing inside windows accessible from the floor, and trash removal.
      (5) Running errands outside the individual's presence that are necessary for the individual's health and safety, like picking up prescriptions or groceries.
      (6) Acting as a travel attendant for individuals.
   ii) Provider Qualifications: **Rule 173-39-02.8 - Ohio Administrative Code | Ohio Laws**
   iii) Authorization Required: Yes
   iv) Billing Guidance:
      (1) S5130 Code/Modifiers: UA, billing unit=15 minutes, limits
      (2) EVV Required: No

10. Home Care Attendant Services
   i. Service involves trained, non-nursing staff providing skilled nursing services, such as medication administration and G-tube feeding and care. In addition to these services, HCAs assist individuals with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and other supportive services to aid the individual's needs.
   ii. Provider Qualifications: **Rule 173-39-02.24 - Ohio Administrative Code | Ohio Laws**
   iii. Authorization Required: Yes

Click to return to Table of Contents

iv. Billing Guidance:
(1) S5125 Code/Modifiers HQ or U8, billing unit=15 minutes, limits
(2) EVV Required: Yes

11. Home Delivered Meals
i) Meal delivery to individuals unable to prepare or obtain nourishing meals independently. These meals are typically intended for those who are frail, homebound, or isolated and may include standard meals, kosher meals, and therapeutic meals tailored to specific dietary needs. The primary aim is to ensure these individuals receive adequate nutrition to support their overall well-being.
ii) Provider Qualifications: **Rule 173-39-02.14 - Ohio Administrative Code | Ohio Laws**
iii) Authorization Required: Yes
iv) Billing Guidance:
(1) S5170 Code/Modifiers U6 or UA, billing unit=1 meal, limits
(2) EVV Required: No

12. Home Maintenance and Chore Services
i) Definition: Designed to ensure a clean and safe living environment by performing tasks within an individual's home that the individual cannot manage independently. The scope of covered activities includes:
(1) **Minor Home Maintenance and Repair:**
(a) Tasks such as inspecting, maintaining, and repairing furnaces (including pilot lights and filters); dealing with water faucets, drains, heaters, and pumps; replacing or installing electrical fuses; conducting plumbing and electrical repairs; repairing or replacing screens or windowpanes; fixing floor surfaces threatening health and safety; and moving heavy objects to ensure clear pathways for safe ingress and egress.
(2) **Heavy Household Cleaning:**
(a) Activities include washing walls and ceilings, exterior window cleaning, non-routine interior window washing, cleaning and rehanging curtains or drapes, and shampooing carpets or furniture.
(3) **Environmental Hazard Removal:**
(a) Addresses threats to health and safety through non-routine garbage disposal, non-routine yard maintenance such as snow removal, pest control tasks, and mold eradication.
(4) **Maintenance of Home Modification or Assistive Devices:**
(a) Includes implementing routine maintenance plans, managing extended warranties, and covering service calls, labor, and parts for modifications or devices that fail to function properly.
These services prioritize the health, safety, and welfare of the individual by addressing essential home maintenance needs.
ii) Provider Qualifications: **Rule 5160-44-12 - Ohio Administrative Code | Ohio Laws**
iii) Authorization Required: Yes
iv) Billing Guidance:
(1) S5121 Code/Modifiers: UB or UA, billing unit=per service, limits: $10,000 annually per individual
(2) EVV Required: No

13. Home Medical Equipment and Supplemental Adaptive and Assistive Devices

i) Definition: Services that provide either rented or purchased medical equipment and supplies to individuals. These services are aimed at enhancing the individuals' ability to function safely and independently in their homes, thus reducing the necessity for admission into nursing facilities.
   (1) HME encompasses:
      (a) Equipment and supplies approved under Chapter 5160-10 of the Administrative Code.
      (b) Miscellaneous equipment and supplies.
      (c) Repairs of equipment.
      (d) Equipment and supplies not covered, either partially or fully, by Medicare, State Plan Medicaid, or any other third-party payer.

   This provision ensures individuals have access to necessary HME products that support their health and independence in a home setting.
ii) Provider Qualifications: **Rule 173-39-02.7 - Ohio Administrative Code | Ohio Laws**
iii) Authorization Required: Yes
iv) Billing Guidance:
   (1) T1999 Code/Modifiers: UA, UAU1, UAU2, UAU3, UAU4, UAU5, UAU6, UAU7, UAU8, UAU9, UAUC, billing unit=per item, limits: price per item needs to be agreed upon prior to service
   (2) EVV Required: No

14. Home Modification Services
   i) Definition: Environmental adaptations made to an individual's private residence, as authorized by their person-centered services plan. These modifications are essential for ensuring the individual's health, welfare, and safety or for enhancing their ability to function independently at home.
      (1) These adaptations may include, but are not limited to:
         (a) Installation of ramps and grab-bars.
         (b) Widening of doorways for easier access.
         (c) Modifications to bathroom or kitchen facilities.
         (d) Installation of specialized electrical and plumbing systems to accommodate necessary medical equipment and supplies.

      Additionally, home modifications encompass the replacement of previous adaptations if they cannot be repaired through other resources. The Ohio Department of Medicaid (ODM), or their designee will approve the most cost-effective solution that fulfills the individual's assessed needs.
   ii) Provider Qualifications: **Rule 173-39-02.9 - Ohio Administrative Code | Ohio Laws**
   iii) Authorization Required: Yes
   iv) Billing Guidance:
      (1) S5165 Code/Modifiers: UA, billing unit=per item, limits $10,000 per calendar year
      (2) EVV Required: No

15. Nutrition Counseling Services
   i) Definition: Involves providing personalized guidance to individuals with specific dietary needs. This service considers various aspects of the individual’s life, including their health status, cultural, religious, and ethnic backgrounds, socio-economic situation, as well as their dietary preferences and restrictions. The goal is to offer tailored nutrition advice that promotes better health and well-being.
   ii) Provider Qualifications: **Rule 173-39-02.10 - Ohio Administrative Code | Ohio Laws**
   iii) Authorization Required: Yes
   iv) Billing Guidance:
      (1) S9470 Code/Modifiers: UA, billing unit=15 minutes, limits
      (2) EVV Required: No

Click to return to Table of Contents

16. Out-of-Home Respite Services
    i) Definition: Services provided to an individual in a setting outside their home, designed to offer rest or relief for their regular caregivers. This service requires an overnight stay and includes:
        (1) **Waiver Nursing Services:** Provided in accordance with rule 5160-44-22 of the Administrative Code.
        (2) **Personal Care Services:** Provided in line with either rule 5160-46-04 of the Administrative Code for individuals on an Ohio Department of Medicaid (ODM)-administered waiver, or rule 173-39-02.11 of the Administrative Code.
        (3) **Meals:** Provision of three meals per day that adhere to the individual's dietary needs.

        It is important to note that all services outlined above, when delivered as part of out-of-home respite, are not billed separately.

    v) Provider Qualifications: **Rule 173-39-02.23 - Ohio Administrative Code | Ohio Laws**
    vi) Authorization Required: Yes
    vii) Billing Guidance:
        (1) H0045 Code/Modifiers, billing unit=1 day, limits
        (2) EVV Required: No

17. Personal Care Services
    i) Definition: Providing hands-on assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), when these are incidental to ADLs, within the individual's home and community.
        (1) **Authorized Personal Care Activities:**
            (a) Assisting with home management, personal affairs, and self-administration of medications, as specified in rule 173-39-01 of the Administrative Code.
            (b) Providing support for ADLs and IADLs.
            (c) Performing homemaker activities as outlined in rule 173-39-02.8 of the Administrative Code, when specified in the individual's service plan and incidental to other personal care activities or essential for the individual's health and welfare rather than for their family.
            (d) Conducting necessary errands outside the individual's presence that are crucial for maintaining their health and safety (such as picking up prescriptions or groceries).
        (2) **Exclusions:**
            (a) Personal care activities do not include offering respite care to the individual's caregiver.
    ii) Provider Qualifications: **Rule 173-39-02.11 - Ohio Administrative Code | Ohio Laws**
    iii) Authorization Required: Yes
    iv) Billing Guidance:
        (1) T1019 Code/Modifiers: UA, UAU1, UAU2, UAU3, UAU4, TUUA, billing unit=15 minutes, limits
        (2) EVV Required: Yes

18. Personal Emergency Response Services (PERS)
    i) Definition: Services designed to promote individuals' independence within the community by providing monitoring, reminder, and/or reporting functionalities. Key components of PERS include telecommunications equipment, a central monitoring station, and provision for two-way, hands-free communication between the individual and the station. Personnel at the station respond to alarms triggered by the individual's PERS equipment.
        (1) **PERS Equipment Characteristics:**
            (a) Must be suitable to meet the assessed needs of the individual, as detailed in their person-centered services plan, and encompass the following features:

(b) A wearable, water-resistant activation device conforming to industry standards for water resistance, aligned with the individual's needs and preferences.
(c) An internal battery capable of providing at least twenty-four hours of power without needing a recharge.
(d) Functionality that addresses the individual's specific needs and preferences.

(2) **Exclusions from PERS:**
(a) PERS does not include remote video monitoring of the individual in their home.
(b) It also excludes systems solely connecting the individual to emergency service personnel.

ii) Provider Qualifications: **Rule 173-39-02.6 - Ohio Administrative Code | Ohio Laws**
iii) Authorization Required: Yes
iv) Billing Guidance:
(1) S5160/S5161 Code/Modifiers: UA, billing unit=per service, limits
(2) EVV Required: No

19. Social Work Counseling Services
i) Definition: Services provided to an individual or their caregiver aimed at enhancing the individual's physical, social, or emotional well-being. These services focus on fostering and maintaining a stable and supportive environment for the individual, contributing to their overall quality of life.
ii) Provider Qualifications: **Rule 173-39-02.12 - Ohio Administrative Code | Ohio Laws**
iii) Authorization Required: Yes
iv) Billing Guidance:
(1) G0155 Code/Modifiers: UA, billing unit=15 minutes, limits
(2) EVV Required: No

20. Structured Family Care
i) Definition: A service provided to individuals aged eighteen or older who are enrolled in the MyCare Ohio waiver program. This service involves the individual residing with a caregiver who delivers daily care and support when the following conditions are met:
(1) The caregiver shares a residence with the individual, either in the individual's private home or in the caregiver's private home.
(2) The individual requires assistance with daily personal care, household support, and activities that foster independence and integration into the community.
(3) The individual opts to receive care through the SFC program.
v) Provider Qualifications: **Rule 173-39-02.25 - Ohio Administrative Code | Ohio Laws**
vi) Authorization Required: Yes
vii) Billing Guidance:
(1) S5136 Code/Modifiers: UD, billing unit=1 day or ½ day, limits
(2) EVV Required: No

21. Waiver Nursing Services
i) Definition: Nursing tasks and activities delivered to individuals who require the expertise of a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of an RN.
ii) Provider Qualifications: **Rule 173-39-02.22 - Ohio Administrative Code | Ohio Laws**
iii) Authorization Required: Yes
iv) Billing Guidance:
(1) T1002 (RN), T1003 (LPN) Code/Modifiers: RN, RNHQ, LP, PLHQ, billing unit=15 minutes, limits
(2) EVV Required: Yes

Click to return to Table of Contents

22. Waiver Transportation
    i) Definition: The use of a provider's vehicle and driver to transport individuals for purposes that are not medical in nature. This transportation service excludes the following:
        (1) Transportation that is already available or funded by Ohio's Medicaid program or other sources.
        (2) Transportation for non-emergency medical purposes.
        (3) Transportation provided through a similar service outlined in the relevant chapter.
        (4) Transportation that the individual's family, neighbors, friends, or community agencies are willing or legally obligated to offer at no cost.
        (5) Escort or transportation services provided by a participant-directed provider, as specified in rule 173-39-02.4 of the Administrative Code.

    v) Provider Qualifications: **Rule 173-39-02.18 - Ohio Administrative Code | Ohio Laws**
    vi) Authorization Required: Yes
    vii) Billing Guidance:
        (1) T2003 and T2025 Code/Modifiers: UAU4, UAU5, UAU3, UAU6, billing unit= 1 trip/round trip, limits
        (2) EVV Required: No

MyCare Required Modifiers

1. **HQ Modifier:** Applies when a provider bills using code T1002, T1003, or T1019 for services delivered in a group setting. The group reimbursement rate will be the lesser of the provider's billed charge or 75% of the Medicaid maximum.
2. **TU Modifier:** Used when billing code T1002, T1003, or T1019 for a claim that is entirely billed as overtime. (FMS provider only)
3. **UA Modifier:** Applicable when billing code T1002, T1003, or T1019 for a claim where only part of it is billed as overtime.
4. **UD Modifier:** Applies to billing code S5136 for a half day of structured family caregiving.
5. **U1 Modifier:** Used with billing code T1002 when an individual is receiving infusion therapy.
6. **U2 Modifier:** Used when the same provider bills using code T1002, T1003, or T1019 for a second visit to an individual on the same date of service.
7. **U3 Modifier:** Used when the same provider bills using code T1002, T1003, or T1019 for three or more visits to an individual on the same date of service.
8. **U4 Modifier:** Applied when billing code T1002, T1003, or T1019 for a single visit lasting more than 12 hours but not exceeding 16 hours.
9. **U6 Modifier:** Used with billing code S5170 for a therapeutic or kosher home-delivered meal.

Common Billing Scenarios & Resolutions

- Correcting denied claims: Submit corrected claim with required information.
- Member eligibility changes mid-month: Confirm coverage before billing.
- Hospital discharge transitions: Coordinate with care manager.
- Overlapping service times: Adjust and rebill with corrected times.

Coordination with Other Payers

Click to return to Table of Contents

- Medicare is primary for dually eligible members; bill Medicaid/MyCare Ohio as secondary.
- Verify and report third-party liability (TPL) before submitting claims.
- Claims must include accurate coordination of benefits (COB) information.

Provider Services: 833-727-2170
https://www.anthem.com/oh/provider/state-federal