Provider Manual

Anthem HealthKeepers Plus plan

Effective July 1, 2026

Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

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CHAPTER 1: INTRODUCTION

Welcome

Thank you for being a part of the Anthem HealthKeepers Plus network, offered by HealthKeepers, Inc.

HealthKeepers, Inc. has been selected by the Commonwealth of Virginia's Department of Medical Assistance Services (DMAS) to provide access to health care services for the Cardinal Care Managed Care program including members in the Family Access to Medical Insurance Security (FAMIS) program.

Cardinal Care Managed Care

Cardinal Care Managed Care, managed by DMAS, is the Medicaid Managed Care program in the Commonwealth of Virginia. It is a statewide mandatory Medicaid program that utilizes contracted managed care organizations (MCOs) like HealthKeepers, Inc. to provide medical services to qualified individuals. The program is approved by the Centers for Medicare & Medicaid Services (CMS) through a 1915(b) waiver. Cardinal Care Managed Care includes members formerly enrolled in Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus).

Medicaid members who are eligible for the Cardinal Care Managed Care program include noninstitutionalized members in the following covered groups:

- Children
- Pregnant women
- Parent caretakers
- Youth in foster care and adoption assistance programs
- FAMIS members
- FAMIS MOMS
- Individuals receiving Long-Term Services and Supports (LTSS)
- Members who are eligible in the aged, blind and disabled (ABD) and Health and Acute Care Program (HAP) Medicaid coverage groups, including ABD and HAP individuals
- Members who receive Medicare benefits and full Medicaid benefits (dual-eligible).
- Members who receive Medicaid long-term services and supports (LTSS) in a facility or through the home- and community-based (HCBS) Commonwealth Coordinated Care Plus Waiver. Individuals enrolled in the Developmental Disabilities (DD) waivers — the Community Living, Family and Individual Supports, and Building Independence Waivers — will enroll for their non-waiver services only. Their DD waiver services will continue to be covered through Medicaid fee-for-service.
- Medicaid Expansion members, adults ages 19-64 who:
  - Are not already eligible for Medicare coverage

- Are not already eligible for a DMAS mandatory coverage group (such as pregnant women or disabled individuals)
- Do not exceed 138% of the federal poverty level, income-wise
- Are identified as medically complex
- Are identified as nonmedically complex

Unless specifically noted, this manual applies to the Cardinal Care program, and the FAMIS program.

The Anthem HealthKeepers Plus team includes the departments and employees performing support activities for members and providers, assisting them in navigating the health care system. They are the primary points of contact for providers in their assigned region. By establishing collaborative, supportive relationships with provider and facility networks, our members' medical homes are the center of the care-delivery system.

Together, we link providers, members and community agencies to resources and provide support and assistance to providers to best serve our members. The team is available to:

- Provide training for health care professionals and their staff regarding enrollment, covered benefits, managed care operations and linguistic services.
- Provide support services, including health education referrals, event coordination, and coordination of cultural and linguistic services.
- Provide care management services to supplement providers' treatment plans and improve members' overall health. They do so by informing, educating and encouraging self-care in the prevention, early detection and treatment of existing conditions and chronic disease.
- Coordinate access to community health education resources for various topics, such as breastfeeding, smoking cessation, diabetes and asthma.

Using This Manual

The most updated version of this manual is on the provider website at **https://providers.anthem.com/va**. Select any topic in the Table of Contents and be taken directly to that topic.

HealthKeepers, Inc. works with nationally recognized health care organizations to stay current on the latest health care breakthroughs and discoveries; this manual provides easy links to access that information. Select any web address and be redirected to that site. Each chapter may also contain crosslinks to other chapters, to the provider website or to outside websites containing additional information. This manual is revised at least once a year.

HealthKeepers, Inc. also provides forms and reference guides providers will need on a wide variety of subjects. If providers have any questions about the content of this manual, they can contact Anthem HealthKeepers Plus Provider Services at **800-901-0020.**

CHAPTER 2: LEGAL AND ADMINISTRATIVE REQUIREMENTS

Proprietary Information

The information contained in this provider manual is proprietary to HealthKeepers, Inc. By accepting this manual, network providers agree to:

- Protect and hold the manual's information as proprietary.
- Use this manual solely for the purposes of referencing information regarding the provision of medical services to Anthem HealthKeepers Plus members.

Privacy and Security

HealthKeepers, Inc.'s latest HIPAA-compliant privacy and security statements can be found in the ***Privacy Section*** at **https://www.anthem.com**.

Throughout this manual, there are instances where information is provided as an example. Because actual situations may vary, this information is meant to be illustrative only and is not intended to be relied upon as guidance for actual situations.

There are also places in this manual with invitations to leave the Anthem HealthKeepers Plus website and enter another site operated by a third party. These links are provided for convenience and reference only. HealthKeepers, Inc. and its subsidiary companies do not control such sites and do not necessarily endorse them. HealthKeepers, Inc. is not responsible for their content, products or services.

Be aware that when travelling from the Anthem HealthKeepers Plus website to another website, whether through links provided or otherwise, providers will be subject to the privacy policies (or lack thereof) of the other websites. HealthKeepers, Inc. cautions providers to determine the privacy policy of such sites before providing any personal information.

Misrouted Protected Health Information

Providers and facilities are required to review all member information received from HealthKeepers, Inc. 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 destroy any misrouted PHI or safeguard the PHI for as long as it is retained as well as contact HealthKeepers, Inc. regarding the situation. HealthKeepers, Inc. is required to inform DMAS within one business day of any security incident/breach. Under no circumstances are providers or facilities permitted to misuse or redisclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, please contact Anthem HealthKeepers Plus Provider Services at **800-901-0020.**

Nondiscrimination Statement

HealthKeepers, Inc. does not engage in, aid or perpetuate discrimination against any person by providing significant assistance to any entity or person that discriminates on the basis of race, color or national origin in providing aid, benefits or services to beneficiaries. HealthKeepers, Inc. does not utilize or administer criteria having the effect of discriminatory practices on the basis of gender or gender identity. HealthKeepers, Inc. 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, HealthKeepers, Inc. 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.

HealthKeepers, Inc. provides health coverage to members on a nondiscriminatory basis, according to state and federal law, regardless of gender, gender identity, race, color, age, religion, national origin, physical or mental disability, or type of illness or condition.

Members who contact HealthKeepers, Inc. with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when a HealthKeepers, Inc. 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. HealthKeepers, Inc. documents, tracks and trends 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**.

HealthKeepers, Inc. provides free tools and services to people with disabilities to communicate effectively. HealthKeepers, Inc. also provides free language services to people whose primary language isn't English (for example, qualified interpreters and information written in other languages). These services can be obtained by calling the customer service number on their member ID card. Interpreter services requests can be scheduled up to one month in advance and no less than five days before a routine visit or 24 hours prior to rendering acute care services.

If a provider or a patient believes that HealthKeepers, Inc. 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, providers, patients or their representative can file a grievance with the HealthKeepers, Inc. grievance coordinator via:

- Mail: HealthKeepers, Inc., Attention: Civil Rights Coordinator for Discrimination Complaints, P.O Box 62509, Virginia Beach, VA 23466-2509.
- Phone: **800-901-0020** for Anthem HealthKeepers Plus
- Fax: **855-832-7294**
- Email: grievancesandappeals-hkp@anthem.com

Provider and Facility Digital Guidelines

HealthKeepers, Inc. 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.

HealthKeepers, Inc. 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 HealthKeepers, Inc. These platforms and applications are accessible to both participating and nonparticipating Providers and Facilities and encompass **https://Availity.com**, electronic data interchange (EDI), electronic medical records (EMR) connections and business-to-business (B2B) desktop integration.

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.

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

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

Claim submissions status and claims payment disputes

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

- EDI transaction: X12 837 – Professional, institutional, and dental Claim submission (version 5010):
  - HealthKeepers, Inc. 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:
  - HealthKeepers, Inc. supports the industry standard X12 276/277 transaction set for Claim status inquiry and response as mandated by HIPAA.
- Availity Essentials – Claims & Payments application:
  - Enables Providers and Facilities to enter a Claim directly into an online Claim form and upload supporting documentation for a defined claim.
  - 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 HealthKeepers, Inc. that electronic Claim payment disputes are adopted when and where they are integrated.

- Provider desktop integration via B2B APIs:
  - HealthKeepers, Inc. 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 **https://Availity.com**:

- EDI transaction: X12 275 – Patient information, including HL7 payload attachment:
  - HealthKeepers, Inc. 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. HealthKeepers, Inc. supports the industry standard X12 835 transaction as mandated per HIPAA.

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

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

To stop receiving ERAs for your claims, contact Availity Client Services at **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 streamlining administrative processes. There are several options to receive claims payments electronically.

- **Electronic Funds Transfer (EFT)**
  Electronic funds transfer (EFT) uses the automated clearinghouse (ACH) network to transmit healthcare payments from a health plan to a Provider's or Facility's bank account at no charge for the deposit. Health plans can use a Provider's or Facility's banking information only to deposit funds, not to withdraw funds. The EFT deposit is assigned a trace number (TRN) to help match the payment to the correct 835 electronic remittance advice (ERA), a process called reassociation.
  To enroll in EFT: Providers and Facilities can register, enroll, and manage account changes for EFT through EnrollSafe at **enrollsafe.payeehub.org**. EnrollSafe enrollment eliminates the need for paper registration. EFT payments are deposited faster and are generally the lowest cost payment method. For help with enrollment, **use this convenient EnrollSafe User Reference Manual**.
  To disenroll from EFT: Providers and Facilities are entitled to disenroll from EFT. Disenroll from EFT payments through EnrollSafe at **enrollsafe.payeehub.org**.
- **Virtual Credit Card (VCC)**
  For Providers and Facilities who don't enroll in EFT, and in lieu of paper checks, HealthKeepers, Inc. 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 HealthKeepers, Inc. 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 HealthKeepers, Inc. 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.

Section 6: Provider Enrollment and Network Management

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.

My Roster:

Providers and Facilities can download roster data through Availity Essentials. This allows the review of data within our system and updates using the formatted file to provide changes.

- To request a roster, go to Availity.com > Payer Spaces > Select Payer Tile > Provider Enrollment and Network Management > Request Current Roster.
- Providers and Facilities will be prompted to select the organization name and TIN they would like included in the roster. Multiple TINs can be included in one request.
- A Roster File Submission confirmation message displays. When the roster is ready to download, it will be available by clicking **Download Requested Roster**. Rosters are usually available within 4 hours. Rosters cannot be requested more than once a day.

Providers and Facilities can edit the downloaded roster and upload the updated version via Availity's Provider Data Management *Upload Roster File* screen to easily make changes to their data. Because the download is correctly formatted, it should enable automatic processing.

**see Section 7: Demographic Updates section for more information about Provider Data Management.*

Provider and Facilities access for Provider Enrollment and Network Management features:

- To access these features, go to Availity.com > Payer Spaces > Select Payer Tile > Provider Enrollment and Network Management application.
- For organizations already using Availity Essentials, the organization's Availity Essentials administrator should go to **My Account Dashboard** from the Availity Essentials home page to register new users and update or unlock accounts for existing users. Staff who need access to the Provider Enrollment and Network Management application need to be granted the role of Provider Enrollment.

Section 7: Demographic updates

Provider Data Management (PDM)

Availity Essentials Provider Data Management (PDM) is the digital intake application for Providers and Facilities to submit demographic change requests – it is also where providers can upload a roster with demographic changes. If submitting a roster, find the TIN/business name for which you want to verify and update information. Before you select the TIN/business name, select the three-bar menu option on the right side of the window, and select Upload Rosters and follow the prompts.

For Provider and Facilities using the roster upload option, additional resources are available:

- **Error Report:**

  - Providers and Facilities can use this Error Report to understand where errors occurred (specifically which sheet, tab, and row), the cause of the issue, and how to fix it.
  - Providers and Facilities are responsible for using the Error Report to identify errors in a roster, correct them, and resubmit the roster rows that contain errors. Rows in a roster that contain an error will not be processed and the addition, change, or termination will not be updated in our systems
- **Results Report:** When a roster has the status partially complete or complete a Results Report will be created for any rosters received on and after June 15, 2024. The Results Report is an Excel file that shows the adds and updates made to your provider group's demographic data based on the information contained in a specific roster.
- **Use the *Roster Submission Guide:*** For Provider and Facilities using the roster upload option, additional information about the Error Report and Results Report can be found in our *Roster Submission Guide*. Find it online at Availity.com > Payer Spaces > Select Payer Tile > Resources > Roster Submission Guide using Provider Data Management.

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

HealthKeepers, Inc. 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.

Updates and Changes

The provider manual, as part of the provider agreement and related addendums, may be updated at any time and is subject to change. In the event of an inconsistency between information contained in the manual and the agreement between providers or their facility and HealthKeepers, Inc., the agreement shall govern.

In the event of a material change to the provider manual, HealthKeepers, Inc. will make reasonable efforts to notify providers in advance of such change through online newsletters, fax communications or other mailings. In such cases, the most recently published information should supersede all previous information and be considered the

current directive. It is the provider's responsibility to review the version posted on the provider website, to be sure they are following the latest version.

The manual is not intended to be a complete statement of all HealthKeepers, Inc. policies or procedures. Other policies and procedures not included in this manual may be posted on the provider website or published in specially targeted communications, such as bulletins and newsletters.

This manual does not contain legal, tax or medical advice. Please consult advisors for advice on these topics.

CHAPTER 3: CONTACTS

Overview

The following resource grid is a consolidation of the most-used phone and fax numbers, websites and addresses found within the manual itself, as well as other valuable contact information for providers and their staff.

Anthem HealthKeepers Plus Provider Services

- Phone: **800-901-0020**
- Fax: **866-408-7087**
- Hours of operation: Monday through Friday, 8 a.m. to 8 p.m. ET

HealthKeepers, Inc. Contact Information

Department/Process	Contact Details
24/7 NurseLine	Anthem HealthKeepers Plus phone: **800-901-0020 (**TTY **711**) Hours of operation: 24 hours a day, 7 days a week; available after normal business hours to verify member eligibility or to obtain over the phone interpreter assistance.
Availity Client Services	**800-282-4548** Monday – Friday 8 a.m. to 8 p.m. ET **https://Availity.com/**
Carelon Behavioral Health, Inc.*	National Provider Service Line **800-397-1630** Monday through Friday, 8 a.m. to 8 p.m. ET
Behavioral Health Services	Anthem HealthKeepers Plus phone: **800-901-0020** Care management: **800-901-0020 option 6** Authorizations should be submitted electronically via **https://Availity.com/**
Benefits, Eligibility, PCP Verification and General Provider Questions	Anthem HealthKeepers Plus phone: **800-901-0020**
Care Management Referrals	Phone: **800-901-0020**

Department/Process	Contact Details
Claims	Anthem HealthKeepers Plus phone: **800-901-0020**
Claims Overpayment	Mail overpayments to: HealthKeepers, Inc. P.O. Box 933657 Atlanta, GA 31193-3657
Contracting	Anthem HealthKeepers Plus phone: **800-901-0020** Monday through Friday, 8 a.m. to 8 p.m. ET LTSS: valtssproviderenrollment@anthem.com
Dental Services (services provided through a contract between DMAS and DentaQuest)	DentaQuest – Smiles for Children Phone: **888-912-3456** **https://www.dentaquest.com/en/providers**
Foster Care Specialty Plan Support Line	If you need to speak to the member's assigned care manager **833-838-2605,** Monday through Friday 8 a.m. to 5 p.m. ET
Grievances and Appeals	Anthem HealthKeepers Plus phone: **800-901-0020** Fax: **855-832-7294.** Hours of operation: 24/7
Member Interpreter Services (Available over the phone, telehealth/video and face-to-face)	Anthem HealthKeepers Plus phone: **800-901-0020 option 6** Members with hearing or speech loss (TDD line): **711** Interpreter services requests can be scheduled up to one month in advance and no less than five days before a routine visit or 24 hours prior to rendering acute care services.
Members with Hearing or Speech Loss	Relay Services Phone: **711** Hours of operation: 24/7

Department/Process	Contact Details
Practice Consultants, Provider Network Representatives	Anthem HealthKeepers Plus phone: **800-901-0020** Monday through Friday, 8 a.m. to 8 p.m. ET Representatives are located throughout the state and can be reached through the central number.
Medical Prior authorization	For Anthem HealthKeepers Plus initial requests for authorizations: Call **800-901-0020** or send via fax to **800-964-3627**. For medical inpatient admissions authorizations: Fax: **866-920-4095** Note: Please do not send faxes with clinical information about inpatient admissions to Provider Services; this holds up review of the admission. For long-term services and supports authorizations: Request via Availity Essentials (preferred method) Call **800-901-0020** or fax to **844-864-7853**. For LTSS Expedited Requests: Fax to **888-235-8390.** The following scenarios meet expedited criteria and should be sent to this line: • Member being discharged from hospital with significant functional changes • A sudden unexpected change in member's living situation or primary unpaid caregiver

Department/Process	Contact Details
	• New Commonwealth Coordinated Care Plus Waiver members whose health, without the start of services, would be jeopardized. If a request is sent to this fax line that does not meet Expedited Criteria, it will be downgraded to Standard and re-rerouted to standard fax line.
Special Investigation Unit	Phone: **866-847-8247**
Transportation (nonemergency)	Reservations/Member Services: Anthem HealthKeepers Plus members: **877-892-3988** Hours of operation 8am -8pm Monday to Friday
Vision Services: EyeMed	Phone: **800-776-8364**

Commonwealth of Virginia Contact Information

Department/Process	Contact Details
Breastfeeding Support Line	Phone: **800-231-2999**
Dental Services: Smiles for Children	Phone: **888-912-3456**
Eligibility	Phone: **833-522-5582**
Enrollment (for members to enroll in/change MCOs)	Phone: **800-643-2273**
Grievances & Appeals: State Fair Hearing	Phone: **804-371-8488**
Hearing or Speech Loss: Relay Virginia	TDD: **800-828-1120 (TTY 711)**
Virginia Department of Aging and Rehabilitative Services	Phone: **804-662-7000** Toll-free: **800-552-5019** Toll-free TTY: **800-464-9950 (or 711)**

Department/Process	Contact Details
Commonwealth of Virginia Department of Medical Assistance Services Medicaid Website	Phone: **804-786-7933** **https://www.dmas.virginia.gov**
CoverVA	Phone: **855-242-8282** **https://coverva.org/en**
Women, Infants and Children (WIC) Program	Phone: **888-942-3663** **www.vdh.virginia.gov/livewell/programs/wic**

CHAPTER 4: COVERED AND NONCOVERED SERVICES

Overview

This chapter outlines some of the specific covered and noncovered services for members. If providers have questions, they can contact Anthem HealthKeepers Plus Provider Services at
800-901-0020.

Covered Services

Below is a grid of covered services; however, it should not be considered an exhaustive listing — Providers should refer to the DMAS website to confirm this information.

Service	**Covered for Cardinal Care Managed Care?**	**FAMIS Children?**	**Covered for Medicaid expansion?** (*in addition to those services covered under Cardinal Care)
Medical Services			
Abortions (limited cases)	**X**[1]	**X**[1]	**X**[1]
Behavioral health: inpatient, outpatient	**X**	**X**	**X**
Behavioral health: temporary detention orders (under certain conditions)	**X**	**X**	**X**
Chiropractic services	**X** (limited)	**X** (limited)	**X**
Clinic services	**X**	**X**	**X**
Colorectal cancer screening	**X**	**X**	**X**
Court-ordered services	**X**	**X**	**X**
Doula services	**X**	**X**	**X**
Early and Period Screening, Diagnosis and Treatment (EPSDT)	**X**		**X**
Emergency services	**X**	**X**	**X**
Family planning	**X**	**X**	**X**
Services related to end-stage renal disease	**X**	**X**	**X**
HIV testing and treatment counseling	**X**	**X**	**X**
Home health services	**X**	**X**	**X**
Hospice services	**X (limited)**	**X**	**X**

Service	Covered for Cardinal Care Managed Care?	FAMIS Children?	Covered for Medicaid expansion? (*in addition to those services covered under Cardinal Care)
Medical Services			
Immunizations/vaccinations	X	X[5]	X
Hospital services (inpatient and outpatient)	X	X	X
Lab and radiology	X	X	X
Mammograms	X		X
Medical supplies and equipment	X	X	X
Nurse-midwife services	X	X	X
Nursing facilities screening	X	X	X
Nurse practitioner services	X	X	X
Obstetric and gynecologic services	X	X	X
Organ transplants	X	X	X
Bone marrow and high-dose chemotherapy for adult members (that is, age 21 and older) diagnosed with breast cancer, leukemia, lymphoma and myeloma	X		X
Bone marrow and high-dose chemotherapy for members diagnosed with lymphoma and myeloma		X	
Liver, heart and lung medically necessary transplants (all ages), including partial or whole coverage	X	X	X
Heart and lung transplants (for children only)	X	X	X
Orthotopic or heterotopic liver transplantation	X	X	X
Single-lung, double-lung or lung-lobe transplants (for children and adults)	X	X	X
Liver or liver-lobe transplants, living or cadaver donor (for children and adults)	X	X	X
Kidney transplants, living or cadaver donor (for children and adults)	X	X	X
Pancreas transplants done at the same time as covered kidney transplants (children only)	X	X	X
Pancreas transplants (for children only)	X	X	X

Service	Covered for Cardinal Care Managed Care?	FAMIS Children?	Covered for Medicaid expansion? (*in addition to those services covered under Cardinal Care)
Medical Services			
Tissue transplants	X	X	X
Autologous, allogeneic or syngeneic bone marrow transplants or other forms of stem-cell rescue (for children)	X	X	X
Cornea transplants (for children and adults)	X	X	X
Small bowel and small bowel with liver transplants (for children only)	X	X	X
Physician services and screenings	X	X	X
Podiatry services	X	X	X
Post-stabilization care following emergency services	X	X	X
Pap smears	X	X	X
Pregnancy-related services	X	X	X
Prescription services	X	X	X
Preventive care	X	X	X
Prostate-specific antigen and digital rectal exams	X	X	X
Prosthetics/orthotics	X	X	X
Prostheses (breast)	X	X	X
Reconstructive breast surgery	X	X	X
Rehabilitation services: inpatient	X	X	X
Respiratory therapy	X	X	X
Speech, hearing and language services	X	X	X
Therapy (speech, occupational and physical)	X	X	X
Telemedicine	X	X	X
Transportation: emergency	X	X	X
Transportation: nonemergency	X		X
Vision services	X	X	X
Well-baby and well-child care	X	X	X
Annual adult wellness exams	X		X*
Individual and group smoking cessation counseling	X	X	X*

Service	Covered for Cardinal Care Managed Care?	FAMIS Children?	Covered for Medicaid expansion? (*in addition to those services covered under Cardinal Care)
Medical Services			
Nutritional counseling for individuals with obesity or chronic medical diseases	**X**	**X**	**X***
Recommended adult vaccines or immunizations	**X**	**X**	**X***
Mental Health Services			
Inpatient psychiatric hospitalization in freestanding psychiatric hospital	**X**	**X**	**X**
Inpatient psychiatric hospitalization in general hospital	**X**	**X**	**X**
State geriatric hospital placements (excluded from Managed Care Program participation)			
Temporary detention orders (TDOs) and emergency custody orders (ECO)	**X**		**X**
Electroconvulsive therapy	**X**	**X**	**X**
Pharmacological management	**X**	**X**	**X**
Psychiatric diagnostic evaluation	**X**	**X**	**X**
Psychological/neuropsychological testing	**X**	**X**	**X**
Smoking/tobacco cessation	**X**	**X**	**X**
Psychotherapy (individual, family and group)	**X**	**X**	**X**
Mental Health Services (MHS) Case management Therapeutic day treatment Intensive in-home services Mental health intensive outpatient services Mental health partial hospitalization services Mobile crisis response Community stabilization 23-hour stabilization/Crisis receiving center Residential crisis stabilization units Assertive community treatment Psychosocial rehabilitation Mental health skill building	**X**	**X (limited)**	**X**

Service	Covered for Cardinal Care Managed Care?	FAMIS Children?	Covered for Medicaid expansion? (*in addition to those services covered under Cardinal Care)
Medical Services			
Applied behavioral analysis Multisystemic therapy Functional family therapy Peer recovery support services (individual and group)			
Addiction Recovery Treatment Services (ARTS)			
Medically managed intensive inpatient services	**X**	**X**	**X**
Medically managed intensive inpatient withdrawal management	**X**	**X**	**X**
Clinically managed high-intensity residential services	**X**	**X**	**X**
Clinically managed population-specific, high intensity residential services	**X**	**X**	**X**
Clinically managed low-intensity residential services	**X**	**X**	**X**
ARTS partial hospitalization	**X**	**X**	**X**
ARTS intensive outpatient services	**X**	**X**	**X**
Ambulatory withdrawal management (with or without extended on-site monitoring)	**X**	**X**	**X**
Medication-assisted treatment • Methadone in opioid treatment program • Buprenorphine/Nalox in opioid treatment program	**X**	**X**	**X**
Substance use case management/care coordination	**X**	**X**	**X**
Outpatient ARTS individual, family and group counseling services	**X**	**X**	**X**
Peer recovery support services (individual and group)	**X**	**X**	**X**
Screening, Brief Intervention and Referral to Treatment (SBIRT) services	**X**	**X**	**X**

Service	Covered for Cardinal Care Managed Care?	FAMIS Children?	Covered for Medicaid expansion? (*in addition to those services covered under Cardinal Care)
Medical Services			
Early Intervention Services			
Targeted care coordination/service coordination services	X[3]	X[3]	X[3]
Early Intervention initial assessments for service planning and development and annual review of the individual family services plan (IFSP)	X[3]	X[3]	X[3]
IFSP team treatment activities	X[3]	X[3]	X[3]
Developmental services (individual and/or group)	X[3]	X[3]	X[3]
Center-based Early Intervention services (individual and/or group)	X[3]	X[3]	X[3]
Early Intervention physical therapy (individual and/or group)	X[3]	X[3]	X[3]
Early Intervention Services			
Early Intervention occupational therapy (individual and/or group)	X[3]	X[3]	X[3]
Early Intervention speech language pathology (individual and/or group)	X[3]	X[3]	X[3]
Developmental nursing (individual and/or group)	X[3]	X[3]	X[3]
Case management for high-risk infants	X[3]	X[3]	X[3]
Dental screenings	X[3]	X[3]	X[3]
Dental varnish	X[3]	X[3]	X[3]
Hearing services	X[3]	X[3]	X[3]
Immunizations	X[3]	X[3]	X[3]
Laboratory tests	X[3]	X[3]	X[3]
Private duty nursing	X[3]	X[3]	X[3]
Periodic health screenings	X[3]	X[3]	X[3]
Vision services	X[3]	X[3]	X[3]
Long-Term Services and Supports (LTSS): Commonwealth Coordinated Care Waiver Cardinal Care Only			
Long-stay hospital			X
Specialized care			X

Service	Covered for Cardinal Care Managed Care?	FAMIS Children?	Covered for Medicaid expansion? (*in addition to those services covered under Cardinal Care)
Medical Services			
Personal care (agency-directed and consumer-directed)			**X**
Respite care (agency-directed and consumer-directed)			**X**
Adult day health care (ADHC)			**X**
Personal emergency response systems			**X**
Skilled private duty nursing			**X**
Assistive technology			**X**
Environmental modifications			**X**
Service facilitations			**X**
Transition services			**X**

Notes:

1 Abortions are covered on a limited basis:

- For Cardinal Care Elective abortions and their related services are not covered. Nonelective abortion services are covered by DMAS. HealthKeepers, Inc. will provide coverage for any necessary follow-up medical care in relation to the abortion services being provided.
- For Cardinal Care Managed Care: HealthKeepers, Inc. will cover induced abortion services when there would be a substantial danger to the life of the mother, as referenced in Public Law 1118. The physician must certify in writing on the basis of their professional judgment that this is the case and include the name and address of the member in that certification. HealthKeepers, Inc. will provide coverage for any necessary follow-up medical care that may be needed in relation to the abortion services being provided.
- For FAMIS Children: DMAS is responsible for payment of abortion services under the fee for service program in accordance with FAMIS State Plan and Federal SCHIP requirements. HealthKeepers, Inc. will provide coverage for any necessary follow-up medical care in relation to the abortion services being provided.

2 Chiropractic care: Chiropractic care is not a covered service, except as medically necessary, in accordance with EPSDT. HealthKeepers, Inc. covers up to $500 per calendar year coverage of medically necessary spinal manipulation and outpatient chiropractic services rendered for the treatment of an illness or injury.
3 These services will be covered under FAMIS/Cardinal Care.
4 Dental services for members are covered by DentaQuest, DMAS' contracted dental benefits administrator.
5 FAMIS Children do not qualify for the free Virginia Vaccines for Children (VVFC) program.

Noncovered Services

Some, but not all, noncovered services include:

- Abortions (with limited exceptions)
- Assisted-suicide services
- Chiropractors (covered for EPSDT only; covered for FAMIS)
- Christian-science nurses and care
- Community intellectual disability case management/care coordination
- Erectile-dysfunction drugs
- Experimental/investigative procedures
- Services for incarcerated members

Medicaid Covered Services

- Services below are not currently covered by Anthem HealthKeepers Plus but are covered by traditional Medicaid.
  - Services provided to members in penal institutions
  - Services provided in skilled nursing facilities
- Long-term institutional care services — covered
- Services provided under hospice in an institutional setting (potential coverage for FAMIS; prior authorization is required) — covered for Anthem HealthKeepers Plus members
- Psychiatric treatment in a state hospital
- Services provided in intermediate care facilities for individuals with intellectual disabilities
- Youth receiving services in PRTFs will maintain enrollment in their Cardinal Care Managed Care Organization (MCO).
- Healthcare services outside of the PRTF per diem and PRTF required services must be billed to the MCO. Examples include physician specialists; pharmacy services; physical therapy; occupational therapy; laboratory and radiology services; durable medical equipment; supplemental nutritional supplies; vision services; outpatient hospital services; emergency services and allowable Mental Health Services (such

as mobile crisis response and limited overlaps with other services to assist with care coordination (Source: Medicaid Bulletin 10/17/2025)

DMAS Covered Services

- Services below are not currently covered by Anthem HealthKeepers Plus but are covered by traditional Medicaid.
  - Services provided to members in penal institutions
  - Services provided in skilled nursing facilities
  - Psychiatric residential treatment facility services
  - Therapeutic group homes

Services that are covered by DMAS and not by HealthKeepers, Inc. include:

- Dental services for adults and children
  - Provided through DentaQuest (Smiles for Children), a dental benefit administrator contracted with the Department of Medical Assistance Services (DMAS). The toll-free number for DentaQuest (Smiles for Children) is **888-912-3456**.
  - Preventive and restorative services for adults. Contact DentaQuest at
  - **888-912-3456** or search the DentaQuest website for more information.
- Developmental disability support coordination
- School health services
- Christian Science Sanatoria and services
- Indian Health Care Providers (IHCP) including tribal clinic providers
- Transportation for waiver-based appointments received transportation services from ModivCare. The toll-free number is **866-386-8331**

Doula Services

Doula services, effective July 1, 2022, is a covered benefit for members enrolled with the Anthem HealthKeepers Plus plan.

Services must be provided by a Doula who is certified by the Virginia Department of Health, as well as registered as a Medicaid provider. Doulas must complete the Federal and State screening process. This benefit includes up to nine touchpoints conducted by the Doula provider to the member, including pre and postpartum visits, as well one Doula touchpoint (attendance) at delivery. Doula services can only be provided in the community, in clinicians' offices (if a Doula is accompanying the member to a clinician visit) or in the hospital. To render the allowed touchpoints (visits), the Doula provider must have a valid Medicaid-issued Doula recommendation form submitted to the health plan prior to rendering services. This referral form can be submitted by a variety of healthcare professionals to include, but not limited to: Physicians, Certified Professional Midwives, Certified Nurse Midwives, Nurse Practitioners, physician assistants, and other Licensed Mental Health Professionals (LMHPs: physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed

substance use treatment practitioner, licensed marriage and family therapist, and certified psychiatric clinical nurse specialist).

Hospice Care

Hospice is a covered benefit for members enrolled with the Anthem HealthKeepers Plus plan who elect hospice services. A member may be in a waiver and also receive hospice services. Children under 21 years of age are permitted to continue to receive curative medical services even if they also elect to receive hospice services.

This includes a program of home and inpatient care provided directly by, or under the direction of, a licensed hospice. Hospice care programs include a palliative and supportive physician as well as psychological, psychosocial and other health services to individuals utilizing a medically directed interdisciplinary team.

Hospice care services must be: 1) prescribed by a provider licensed to do so, 2) furnished and billed by a licensed hospice, and 3) medically necessary. Hospice care services are available if the member is diagnosed with a terminal illness with a life expectancy of fewer than six months. Hospice care is available concurrently with care related to the treatment of a child's condition if a diagnosis of terminal illness has been made.

For Anthem HealthKeepers Plus enrolled members, all services associated with the provision of hospice services are a covered benefit.

Pharmacy Benefit

HealthKeepers, Inc. administers its pharmacy benefit and establishes prior authorization requirements in accordance with all applicable state and federal laws and regulations. HealthKeepers, Inc. distributes pharmaceutical management procedures to practitioners by mail, fax, email or on its website, if it informs practitioners that the information is available online. HealthKeepers, Inc. mails pharmaceutical management procedures to practitioners who do not have fax, email or internet access.

CarelonRx, Inc. is the pharmacy benefits manager (PBM) for Anthem HealthKeepers Plus members in Virginia. Pharmacy providers bill the PBM for:

- Prescription drugs approved by the U.S. Food and Drug Administration (FDA)
- Over-the-counter (OTC) items approved by the FDA
- Self-injectable drugs (including insulin)
- Smoking-cessation drugs
- Various equipment (for example, needles, syringes, blood sugar monitors, test strips, lancets and glucose urine testing strips)

Only drugs listed on the drug formulary are covered. Providers can find the drug formulary on the provider website at **https://providers.anthem.com/va**.

Drugs not covered by the pharmacy benefit include those that are:

- Not approved by the FDA
- Not on the drug formulary
- Prescribed to help members get pregnant
- Used for cosmetic reasons (agents used in the treatment of covered Gender Dysphoria services are not considered cosmetic)
- For hair growth
- Used to treat erectile problems
- Used for anorexia or weight gain
- Experimental or investigational, except for children and youth covered under EPSDT
- Recalled
- Designated as Drug Efficacy Study Implementation (DESI), including compound drugs that include a DESI drug
- Marketed by a manufacturer that does not participate in the Medicaid Drug Rebate program

Providers will submit all pharmacy claims as well as prior authorization requests to HealthKeepers, Inc. Providers may call Anthem HealthKeepers Plus Provider Services at **800-901-0020** or visit the website at **https://providers.anthem.com/va** for access to the Preferred Drug List and prior authorization information.

Pharmacy Prior Authorization

For any drugs that require prior authorization, provider must contact HealthKeepers, Inc. HealthKeepers, Inc. will provide a response by telephone or other telecommunication device within 24 hours.

The pharmacy prior authorization form is available on our provider website at: **https://providers.anthem.com/docs/gpp/VA_CAID_PriorAuthorizationForm.pdf**

Preferred Drug List

The prescription drug benefit covers at least the same level of services as the base benchmark pharmacy benefit, including one drug in every category and class or the number of drugs covered in each category and class as the base benchmark, whichever is greater.

The HealthKeepers, Inc. Pharmacy and Therapeutics Committee (P&T) meets regularly to make recommendations for changes to the PDL and/or formularies. HealthKeepers, Inc. will submit the proposed change to DMAS for review and/or approval.

Providers can find the Preferred Drug List on the provider website at **https://providers.anthem.com/va**. Refer to the Preferred Drug List for a full listing of prescriptions that require prior authorization.

Covered and Noncovered Drugs
With some exceptions, HealthKeepers, Inc. covers retail and specialty drugs on the Anthem HealthKeepers Plus formulary, including brand-name drugs, generic prescription drugs, and certain prescribed over-the-counter drugs (including insulin).

Excluded prescription drugs typically include:

- Certain brand name drugs where a generic substitution is possible, per Virginia pharmacy law
- Cosmetic/hair growth drugs, except as used in the treatment of Gender Dysphoria as noted above
- Experimental or investigational drugs, except for children and youth covered under EPSDT as noted above
- Fertility drugs
- Sexual dysfunction drugs (oral and injectable)

Note: Noncovered is not the same as prior authorization required. Noncovered drugs are those that are excluded from benefit coverage. These products are not available even with prior authorization. Prior authorization criteria are set to allow for coverage if certain predetermined criteria are met.

Generic Drug Policy
Generic drugs should be provided when available except where DMAS requires the branded product. When a generic drug is available, brand-name products will only be approved through written request using the ***Pharmacy Prior Authorization Form***.

The following guidelines apply when generic prescriptions are substituted with a brand-name prescription:

- If the prescribed brand-name medication has a generic equivalent and the prescribing provider has not requested “dispense as written,” only the FDA-approved generic equivalent will be covered.
- If the generic equivalent medication is not medically appropriate, the provider is required to submit a ***Pharmacy Prior Authorization Form*** for the brand-name medication.
- If the request meets the approval criteria, it will be approved, and the brand name medication will be covered for one year.
- If the request does not meet the approval criteria, only the generic equivalent will be covered.

Note: Mandatory generic substitutions are not applicable for brand name medications that are narrow therapeutic index drugs.

One of the following criteria must be met for members to receive brand name prescriptions instead of generic equivalents:

- The member failed adequate trials of the branded medication's generic equivalent.
- The member has an allergy or contraindication to the generically equivalent product and the prescribing physician determines the brand medication is medically necessary.

If a member request for a brand name drug is denied, one of the following denial criteria must be met:

- Member has not had a trial of the generic product and does not have an allergy or contraindication to the generic product.
- The prescribing provider has not declared the brand-name medication to be medically necessary.

Electronic Prescription Activity

HealthKeepers, Inc. supports electronic prescribing technologies to communicate the PDL and formularies to prescribers. This is done through electronic medical records (EMRs) and e-prescribing applications. HealthKeepers, Inc. encourages the utilization of e-prescribing technologies to ensure appropriate prescribing to members, based on the member's benefit plan. Much of the e-prescribing activity is supported by prescribing providers through web- and office-based applications or certified electronic health record (I) systems to communicate with the pharmacies.

Emergency Medication Fill

HealthKeepers, Inc. covers a 72-hour supply of a covered outpatient prescription drug in an emergency situation. Pharmacists can dispense the 72-hour supply using a claim override process, without the need for a phone call to the plan. The pharmacist should follow up with the member's physician or HealthKeepers, Inc. the next business day regarding the prior authorization requirement.

HealthKeepers, Inc. will conduct retrospective drug use reviews to identify patterns of fraud, abuse, gross overuse, inappropriate care or medically unnecessary care among:

- Individuals receiving benefits.
- Physicians associated with specific drugs or groups of drugs.
- Pharmacies associated with specific drugs or groups of drugs.

Patient Utilization Management and Safety

DMAS requires the use of a Patient Utilization Management and Safety program (PUMS) to coordinate care and ensure that Anthem HealthKeepers Plus members are accessing and utilizing services in an appropriate manner. PUMS is a utilization control and case management/care coordination program designed to promote proper medical management of essential healthcare. Members may be locked into a single pharmacy, PCP, controlled-substances prescriber, hospital (for nonemergency hospital services only) and/or, on a case-by-case basis, other qualified provider types for a 12-month period. If a patient is enrolled in the PUMS program, their provider will be notified.

PUMS placement criteria:

1. **PUMS1 Opioid Use Disorder (OUD) Case Management:** HealthKeepers, Inc. may review any members receiving OUD and provide case management;
    a. Members with any history of opioid overdose(s) in the past three (3) years; ER visits, inpatient hospitalization, or inpatient rehabilitation stay related to OUD in the past three (3) years; pregnant individuals with OUD; individuals with OUD with current or recent involvement (in the past three (3) years) with the criminal justice system: must be evaluated for case management and referred as appropriate; and
    b. Clinical expertise and judgment must be used to identify and manage any members the plan determines should be placed in, or remain in, a lock-in to a prescriber or practice group ("cluster").
2. **PUMS2 High Average Daily Dose**: ≥ ninety (90) cumulative morphine milligram equivalents (MME) per day over the past ninety (90) days;
3. **PUMS3 Opioids and Benzodiazepines concurrent use**: at least one (1) Opioid claim and fifteen (15) day supply of Benzo (in any order);
4. **PUMS4 Doctor and/or Pharmacy Shopping**: ≥ three (3) prescribers OR ≥ three (3) pharmacies writing/filling claims for any controlled substance in the past sixty (60) days;
5. **PUMS5 Use of a Controlled Substance with a History of Dependence, Misuse, or Poisoning/Overdose:** Any use of a controlled substance in the past sixty (60) days with at least two (2) occurrences of a medical claim for controlled Substance Misuse or Dependence in the past three hundred and sixty-five (365) days; and
6. **PUMS6 History of Substance Use, Use or Dependence or Poisoning/Overdose:** Any Member with a diagnosis of substance use, substance misuse, or substance dependence on any new* claim in any setting (for example, ED, pharmacy, inpatient, outpatient, etc.) within the past sixty (60) days.

Note: The pain management contract is a written agreement between a provider and member that the member will not misrepresent his or her need for medication. If the contract is violated, the provider has the right to disenroll the member from the practice.

Dental Services

Dental services are provided through DentaQuest (Smiles for Children), a dental benefits administrator contracted with DMAS. The toll-free number for DentaQuest (Smiles for Children) is **888-912-3456**.

Dental services are not covered by HealthKeepers, Inc., **except** for the circumstances outlined below:

- Resulting from an accident
- Medically necessary procedures for adults or children
- Medically necessary anesthesia and hospitalization services, when determined such services are required to provide dental care

All transportation and medication services related to dental services will be covered by HealthKeepers, Inc. For more information on transportation services, see the **Access Standards and Access to Care** chapter.

Dental Screenings

At each physical examination for a child at any age, an oral inspection must be performed by the EPSDT screening provider. Tooth eruption, caries, bottle-tooth decay, developmental anomalies, malocclusion, pathological conditions or dental injuries must be noted. The oral inspection is not a substitute for a complete dental evaluation provided through direct referral to a dentist.

Dental coverage is provided under the DMAS Medicaid Fee -For-Service Program. For questions, providers can call **855-208-6334**.

DentaQuest will fax authorization requests for facility and anesthesia to the prior authorization team at **800-964-3627**.

Vision Services

Vision services are covered for:

- Anthem HealthKeepers Plus members
  - Routine comprehensive eye examinations for all members shall be allowed at least once every year (includes FAMIS MOMS members)
  - For members under age 21, a pair of glasses (one frame and two lenses) are covered at least once every two years. Contact lenses are covered if medically necessary.
  - Effective September 1, 2022, vision assessments and eyeglasses are covered when provided in a school setting by a mobile vision provider.
  - For members ages 21 and older, members also receive $150 towards eyewear (one frame and two lenses) every year. Contact lenses are covered if medically necessary.

- FAMIS (CHIP Program) members
  - Routine comprehensive eye examinations for all members shall be allowed at least once every two years.
  - A pair of glasses (one frame and two lenses) are covered at least once every two years. Contact lenses are covered if medically necessary.
- Vision services are provided by EyeMed Vision Care. For member eligibility or claims questions, please call **800-776-8364**.

Vision services may be provided by the following:
- Ophthalmologists
- Optometrists
- Opticians

Behavioral Health Services

For information about behavioral health services, please see the **Behavioral Health Services** chapter. Members may self-refer for any mental health or addiction recovery treatment services with the exception of mobile crisis response (which requires dispatch from 988 call centers) and community stabilization (which requires referral from a higher level of care).

Laboratory Services

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

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

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

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

To be considered for reimbursement of reference laboratory services, the referring laboratory must be an independent clinical laboratory. Modifier 90 must be submitted to denote the referred laboratory procedure. Per the Centers for Medicare & Medicaid (CMS), an independent clinical laboratory that submits claims in paper format may not combine non-referred or self-performed and referred services on the same CMS-1500 claim form. Thus, when the referring laboratory bills for both non-referred and referred tests, it must submit two separate paper claims: one claim for non-referred tests and the other for referred tests. If submitted electronically, the reference laboratory must be represented in the 2300 or 2400 loop, REF02 element, with qualifier of F4 in REF01.

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

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

County and State-Linked Services

To ensure continuity and coordination of care for members, HealthKeepers, Inc. enters into agreements with local public health programs. Providers are responsible for notifying our Case Management department via phone at **800-901-0020 option 6** or fax to **866-920-4097** when a referral is made to one of the agencies listed in the **State Services and Programs** section below.

This notification ensures that case management/care coordination nurses and social workers can follow up with members to coordinate their care. The case management/care coordination team works with provider partners to ensure that members receive all necessary services.

State Services and Programs

The following information identifies state services and programs as well as the services these state programs provide upon referral.

Essential Public Health Services

HealthKeepers, Inc. collaborates with public health entities in all service areas to ensure members receive essential public health services. Services include:

- Coordination and follow-up of suspected or confirmed cases of childhood lead exposure
- Appropriate public-health reporting (communicable diseases and/or diseases preventable by immunization)
- Notification and referral of communicable disease outbreaks involving members
  - Investigation, evaluation and preventive treatment of persons with whom the member has come into contact
- Referral for tuberculosis and/or sexually transmitted infections or HIV contact
- Referral for Women, Infants, and Children (WIC) programs and information sharing

Reportable Diseases

By state mandate, providers must report communicable diseases and conditions to local health departments. Providers are to comply with all state laws on reporting

communicable diseases and conditions. Timely reporting is vital to minimize outbreaks and prevalence.

WIC Referrals
The WIC program provides healthy food to pregnant women and mothers of young children. Providers have the following responsibilities for WIC program referrals:

- Complete the WIC Program Referral Form that documents the following information:
- Anthropometric data (height, current weight, pregravid weight)
- Any current medical conditions
- Biochemical data (hemoglobin and hematocrit)
- Expected date of delivery
- Provide member completed referral form, to present at the local WIC agency

The Virginia WIC Program Referral Form is located on the state's website at **www.vdh.virginia.gov/wic** or by calling **888-942-3663**.

Incontinence Supplies for Anthem HealthKeepers Plus Members

If an Anthem HealthKeepers Plus member leaves our plan and is covered under the Department of Medical Assistance Services' (DMAS) fee-for-service program, the member will need to access incontinence supplies through Home Care Delivered, the DMAS sole source contractor for incontinence supplies.

A member's enrollment with our plan is subject to change each month. Providers must hold the member harmless from liability for the cost of any services provided incorrectly due to failure to verify member eligibility and enrollment.

CHAPTER 5: LONG TERM SERVICES AND SUPPORTS (LTSS)

Overview

HealthKeepers, Inc. covers a wide variety of long-term services and supports (LTSS) that help elderly individuals and/or individuals with disabilities with their daily needs for assistance and improve the quality of their lives. These services are covered under the Cardinal Care program.

LTSS are provided over an extended period, predominantly in the homes and communities but also in facility-based settings such as nursing facilities. Examples include assistance with bathing, dressing, and other basic activities of daily life and self-care as well as support for everyday tasks such as laundry, shopping and transportation.

Pre-Admission Screening (PAS)

The PAS team is an entity contracted with DMAS and is responsible for performing pre-admission screening for nursing facilities (NFs) or, if qualified, Commonwealth Coordinated Care Plus Waiver services. Initial determinations for members seeking enrollment in the Commonwealth Coordinated Care Plus Waiver or admission to an NF will be conducted by the PAS team using the Uniform Assessment Instrument (UAI) and other required PAS forms including:

- DMAS-96 (Medicaid Funded Long-Term Care Service Authorization Form)
- DMAS-97 (Individual Choice - Institutional Care or Waiver Services Form)
- DMAS-108 (for adults) or DMAS 109 (for children) for individuals who are technology dependent

If the member is enrolled in the Commonwealth Coordinated Care Plus Waiver or admitted to an NF **before** enrolling in the Cardinal Care program, HealthKeepers, Inc. will obtain a copy of the UAI from the existing provider/NF when possible.

If a member's screening determinations are completed **after** enrolling in the Cardinal Care program, the PAS information will be submitted to HealthKeepers, Inc. by the PAS team. HealthKeepers, Inc. will use information obtained from the UAI in the assessment/individual care plan (ICP) process.

Commonwealth Coordinated Care Plus Waiver

The Commonwealth Coordinated Care Plus Waiver replaces the Elderly or Disabled with Consumer Direction (EDCD) Waiver and Technology Waiver and covers a range of community support services for individuals who are aged, have a disability, or rely on a device for medical or nutritional support (for example, ventilators, a feeding tube or tracheostomy). Individuals who are technology-dependent are chronically ill or severely

impaired, having experienced loss of a vital body function, and require substantial and ongoing skilled nursing care to avert death or further disability.

Covered Services for Commonwealth Coordinated Care Plus Waiver Members

HealthKeepers, Inc. provides the following covered services as part of the overall benefits packages for members enrolled in the Commonwealth Coordinated Care Plus Waiver. Any modification to covered services will be communicated through a provider newsletter, provider manual update and/or contractual amendment. The scope of benefits includes the following:

- Respite care (agency or consumer directed)
- Adult day health center services
- Personal care services (agency or consumer directed)
- Personal emergency response system services
- Medication monitoring
- Transition coordination
- Transition service funding
- Assistive technology
- Environmental modifications

Referral to the Commonwealth Coordinated Care Plus Waiver

Providers and Cardinal Care care managers can refer members for evaluation of eligibility to receive Commonwealth Coordinated Care Plus Waiver services. Family members and caregivers also may refer members for evaluation. The evaluation is conducted by a local pre-admission screening (PAS) team through the local Department of Social Services (DSS), Virginia Department of Health (VDH), a nursing facility, or the acute care hospital. The team verifies the member's eligibility for Medicaid and conducts a functional and medical needs assessment to assess the appropriateness for long-term care services. The PAS team also documents the member's preferences for institutional nursing home care or community-based care through the Commonwealth Coordinated Care Plus Waiver.

To refer a member to the Commonwealth Coordinated Care Plus Waiver, providers may contact DSS or DMAS. More information is available on the DMAS website at **https://dmas.virginia.gov/for-providers/long-term-care/waivers/**.

Cardinal Care Program

Responsibilities of the Cardinal Care Provider

- All facility-based providers and home health care agencies must notify a Cardinal Care case manager/care coordinator within 24 hours when a member dies, leaves the facility or moves to a new residence.

- LTSS providers must participate in the member's interdisciplinary care team, in accordance with the member's needs and preferences.
- LTSS providers must participate in all applicable audits.
- LTSS providers must comply with all provider requirements established in the DMAS provider manuals.
- LTSS providers of Commonwealth Coordinated Care Plus Waiver services (including adult day health care) must maintain compliance with the provisions of the CMS Home and Community-Based Settings Rule, as detailed in 42 CFR 441.301(c)(4) and (5), prior to executing a contract.
- LTSS providers must comply with DMAS-required screening processes, including but not limited to: verifying licenses, revalidations at least every five years, site visits for providers categorized under federal and state program integrity rules and plans at moderate or high risk, criminal background checks as required by state law, federal database checks, and the collection and review of ownership and control disclosures.

Identifying and Verifying the Cardinal Care Member
Upon enrollment, HealthKeepers, Inc. will send a welcome package to the member. This package includes an introductory letter, a member ID card and a Member Handbook. Each Cardinal Care member will present a Cardinal Care ID card with the Cardinal Care logo to identify himself or herself prior to receiving services by, which includes a member number.

Providers can verify member eligibility in several ways:
- Log in to the Virginia Medicaid Enterprise System at **https://vamedicaid.dmas.virginia.gov/.**
- Call the DMAS automated response system (ARS) at **800-884-9730** or **800-772-9996**.
- Log in to **https://Availity.com**.
- Contact Anthem HealthKeepers Plus Provider Services at **800-901-0020**

Nursing Home Eligibility
In the Cardinal Care Managed Care program, the initial level of care (LOC) (including custodial nursing home or skilled nursing facility) is determined by the pre-admission screening team.

For members who reside in a nursing home, the care coordinator will complete the Health Risk Assessment (HRA) within 60 days of the member's enrollment via a face-to-face meeting. During this process, the care coordinator will incorporate Minimum Data Set 3.0 (MDS 3.0) into the plan of care.

The nursing facility would complete the DMAS-225 Medicaid LTC Communication Form (DMAS-225) for communication between the Department of Social Services and the facility regarding financial eligibility, patient liability or any event that may change the financial eligibility/patient liability amount. The DMAS-225 is located at: **https://www.dmas.virginia.gov/media/p1ibjawb/dmas-225-form-with-mco-instructions.pdf**.

For members admitted to a nursing facility under one of the Special Circumstances identified in 12 VAC 30-60-302 who do not have a Medicaid LTSS screening, the Cardinal Care program will accept the MDS and may request the DMAS-80, Nursing Facility Admission, Discharge or Level of Care form. For members in a nursing facility prior to July 1, 2019, in the event that a Medicaid LTSS screening has not been completed, the Cardinal Care program will accept the MDS, and may request the DMAS-80 form.

Consumer Direction

Consumer direction is a process by which eligible home- and community-based services (HCBS) are delivered; it is not a service. Commonwealth Coordinated Care Plus Waiver members will be offered the choice of a consumer-directed model when the need for personal or respite care is identified. Member participation in consumer direction of HCBS is voluntary; they may elect to participate in or withdraw from consumer direction of HCBS at any time without affecting their enrollment.

Consumer direction affords members the opportunity of having choice and control over who provides eligible HCBS and how. It is offered for members who, through the needs assessment/reassessment process, are determined by service coordinators to need any service DMAS specifies as available for consumer direction. These services include personal care and respite care. A service that is not specified in DMAS rules and regulations as available for consumer direction cannot be consumer-directed.

If a member chooses not to direct his or her care, he or she will receive authorized HCBS through network providers. Members who participate in consumer direction of HCBS choose either to: 1) serve as the employer of record for their workers or 2) designate a representative to serve as the employer of record on his or her behalf. The member must arrange for the provision of needed personal care and does not have the option of going without needed services.

HealthKeepers, Inc. will contract with Public Partnerships, LLC. as our Fiscal Employer Agent (F/EA) to provide the following services to Commonwealth Coordinated Care Plus Waiver members who choose consumer direction:

- Criminal background checks for consumer-directed employees with appropriate follow-up and communication to appropriate individuals

- Payroll expenses for authorized hours actually worked by consumer-directed employees, inclusive of employer share of state and federal taxes net patient pay

The F/EA will withhold patient pay amounts from employees' checks. The HealthKeepers, Inc. payments or payroll to the F/EA shall reflect (that is, the net of) the patient pay amount. Claims payment will be provided to the F/EA for authorized eligible Commonwealth Coordinated Care Plus Waiver services as well as EPSDT services provided by consumer-directed employees.

Consumer Direction: Service Facilitators
A consumer direction service facilitator is a facility, agent, person, partnership, corporation or association that meets the standards and requirements established by DMAS. They provide supportive services to members that have elected to enroll in consumer direction by assisting them with the hiring, training, supervising and firing responsibilities of the personal care and respite care aides/attendants.

The Code of Federal Regulations, 42 U.S.C. § 441.450(c), requires that service facilitators are accessible to individuals choosing consumer direction services. The role of the service facilitator is to:

- Make sure the individual gets the services needed and they are on the service plan.
- Review the ***Member Handbook*** with the individual and the family/caregiver as appropriate.
- Train the individual on the required tasks of an employer.
- Develop, with the individual, service plans and paperwork.

Individuals may discuss employer concerns and questions with the service facilitator at any time. The service facilitator **must** be an enrolled Medicaid provider for service facilitation. Also, the service facilitator **cannot** be:

- The individual receiving services.
- The individual's spouse.
- The individual's parent (if the participant is a minor).
- A family member/caregiver who is also the CD employer.

The service facilitator will file claims for the services they provide and follow the applicable codes established by DMAS for consumer-directed service facilitation. For claims filing information, please refer to the **Claims and Billing** chapter.

Agency Services
Members in the Commonwealth Coordinated Care Plus Waiver who do not elect the consumer directed option may receive personal and respite care services through home care agencies that contract with HealthKeepers, Inc. They may be provided in the member's home by home care agency staff with authorization from HealthKeepers, Inc.

The member's service needs and preferences are determined initially and documented by the pre-admission screening team. The member's care manager will receive a copy of the documentation for inclusion in the member's care plan.

The Cardinal Care care manager has primary responsibility for conducting a comprehensive assessment of the member's needs, developing a plan of related services and documenting those services in a member-centered care plan. The care manager will coordinate with the home care agency to authorize and implement needed services, including Commonwealth Coordinated Care Plus Waiver services.

If agency staff believes that additional services are required for a member, they should contact the member's care manager to discuss the need and obtain authorization. The member's care manager also may arrange for other Commonwealth Coordinated Care Plus Waiver services as necessary, such as adult day health care, personal emergency response system, assistive technology and/or environmental modifications. The care manager convenes an interdisciplinary care team as needed to review the member's care. Home health agency staff may be requested to participate in the interdisciplinary care team if requested by the member.

Transition and Discharge Planning to the Community

HealthKeepers, Inc. assists with discharge planning, either to the community or through a transfer to another facility, if the care coordinator (with the member's approval), member or responsible party so requests. If the care coordinator, member or responsible party requests a discharge to the community, the care coordinator will:

- Collaborate with the nursing facility (NF) social worker to convene a planning conference with the NF staff to identify all potential needs in the community.
- Facilitate a home visit to the residence where the member intends to move to assess environment, durable medical equipment (DME) and other needs upon discharge.
- Convene a discharge planning meeting with the member and family, using the data compiled through discussion with the NF staff as well as the home visit, to identify member preferences and goals.
- Collaborate with community organizations such as Centers for Independent Living (CILs) or Area Agencies on Aging (AAAs) to assist members as they transition to the community.
- Finalize and initiate execution of the transition plan.

Although our member-centric approach is driven by the member, transition is a joint effort between the NF facility staff and case manager(s)/care coordinator(s).

Electronic Visit Verification System

Electronic visit verification (EVV) is a telephone- and computer-based system that electronically verifies when service visits occur and documents the precise time service

begins and ends. The purpose of the EVV system is to verify individuals are receiving the services authorized for their support and for which the state or HealthKeepers, Inc. is being billed.

Patient Pay/Member Liability for Commonwealth Coordinated Care Plus Waiver members

The patient pay amount is the member's contribution toward care they receive in a calendar month. Patient pay is tracked monthly, as claims are processed, and will be deducted from each claim until patient liability is met for custodial nursing care, adult day health care, and agency directed personal care for members in the Commonwealth Coordinated Care Plus Waiver.

Patient pay will be deducted on a first-in (that is, the date of adjudication)/first-out basis until fully deducted. Patient pay will not be dedicated to a specific provider; it may be deducted from multiple providers in a given month if there is a transition from one long-term care facility to another long-term care facility, from an HCBS waiver to a long-term care facility or from a long term care facility to an HCBS waiver. Patient pay also may be deducted from multiple providers for members on HCBS waivers who receive multiple services included in patient pay processing in the month.

The only exception is for those choosing to self-direct their personal care services (that is, the consumer direction option). When consumer-directed services are authorized, the Fiscal Employer Agent, Public Partnerships LLC, will be responsible for deducting patient pay from any payments made for consumer-directed services. In this situation, patient pay will not be deducted from other claims paid by HealthKeepers, Inc.

If the patient pay is updated after the claims are processed, those claims will not automatically be reprocessed; HealthKeepers, Inc. receives a quarterly discrepancy report from DMAS listing the paid claims associated with retroactive, patient-pay changes made during the prior month, and will make adjustments for those claims.

Patient Pay/Member Liability for Nursing Facilities

The nursing facility is responsible for collecting the patient pay amount each month. The payment remitted by HealthKeepers, Inc. will be reduced by the patient pay amount. The nursing facility should also complete a DMAS-225 form and send it to the case worker so the level of care is updated appropriately in the state's system.

If providers receive an administrative adverse determination and believe the decision was in error, they may refer to the **Grievances and Appeals** chapter for information and instructions on medical necessity appeals and grievances, and refer to the **Claims and Billing** chapter for payment disputes.

Upon approval of nursing-facility eligibility, the Virginia Department of Social Services will issue a notice of action identifying the patient pay for the first month of eligibility and for the subsequent months. The provider can then collect the identified patient pay amount. The following situations and responses are provided to assist you with addressing patient pay collection:

Example 1: The patient is approved for institutional nursing facility eligibility as of the 15th of the month of a 30-day month.

- The state issues a notice of action for the month for the amount of $500 and for the following month forward of $1,000 per month.
- The facility per diem is $150: 150 x 15 = $2,250.
- The facility collects the $500 patient pay and bills HealthKeepers, Inc. for $2,250.
- HealthKeepers, Inc. will reduce the $2,250 by $500 and remit $1,750.

If a patient is discharged to his or her home or expires mid-month, the provider may retain the patient pay up to the total charges incurred for the month before discharge.

Example 2: The patient is approved for institutional nursing facility eligibility as of the first of the month and is discharged during the month.

- Patient pay is $1,000.
- Per diem is $150.
- Member is discharged on day seven: 7 x $150 = $1,050.
- Provider retains all of the patient pay.
  OR:
- Patient is discharged on day three: 3 x $150 = $450.
- Provider refunds $550 to the patient/family or estate.
- Provider submits a claim to HealthKeepers, Inc. for three days and HealthKeepers, Inc. reduces the payment by the patient pay and issues a $0 claim payment.

If a member transfers facilities mid-month, the eligibility office:

1. Is contacted regarding the impending transfer and expected dates.
2. Issues a notice of action to the discharging facility for the patient pay it will collect for the discharge month.
3. Issues a notice of action to the receiving facility for the patient pay it will collect in the first month and for subsequent months.

HealthKeepers, Inc. recognizes the unique challenges faced by nursing facility (NF) and providers. HealthKeepers, Inc. will provide intensive training for providers to address a member/family that is noncompliant in paying the patient pay including facilitating a transfer if the issue cannot be resolved.

Patient Pay/Member Liability Issue Resolution
The paragraphs below outline our plan for working with the provider and the member/family to resolve patient pay issues.

1. The provider administrator or office manager contacts the Cardinal Care service coordinator with details regarding the lack of patient pay payment, including:
   - The date the last payment was made.
   - Discussions held with the member/family to date.
   - Correspondence between the member/family to date.
   - History of late and/or missed payments, if applicable.
   - Any knowledge of family dynamics, concerns regarding the responsible party or other considerations.

2. A Cardinal Care care coordinator and the provider discuss the issue with the member, determine the barrier to payment and elicit cooperation.
   - The Cardinal Care care coordinator guides the discussion using predetermined talking points including review of the obligation, potential impact to ongoing eligibility, the potential threat to continued residence at the current nursing facility or the ability to continue use of the provider.
   - The Cardinal Care care coordinator will discuss the issue with the identified responsible party if the member is unable to engage in a discussion regarding payment of the patient pay due to cognitive impairment or other disabilities.
   - The Cardinal Care care coordinator also screens for any potential misappropriation of funds by the family or representative payee.

3. The Cardinal Care care coordinator or provider staff will take action if concerns related to misappropriation of funds are raised or suspected and may:
   - Refer the member to Adult Protective Services and/or law enforcement.
   - Submit a request to the Social Security Administration to change the representative payee status to the person of the member's choosing or the nursing facility/provider.
   - Engage additional family members.
   - Engage the Guardianship Program to establish a conservator or guardian.

The Cardinal Care care coordinator will request proof that the member has met their patient pay obligation. The care coordinator will present evidence of payment to the provider's business office and request confirmation that the issue is resolved. The Cardinal Care care coordinator will also engage the assigned Cardinal Care Provider Relations representative to work with the provider to improve its processes.

HealthKeepers, Inc. will send correspondence that outlines the obligation to pay the patient pay, potential impact to ongoing eligibility and potential threat to continued residence at the current nursing facility if the responsible party is unresponsive and/or

living out of the area. This same process will also apply for Commonwealth Coordinated Care Plus Waiver providers in that a communication will be sent to the member reminding them of their obligation to pay and the potential loss of the continued use of services being provided by the Commonwealth Coordinated Care Plus Waiver provider.

The correspondence will be submitted to DMAS for review and approval as required. The correspondence will provide the responsible party with an opportunity to dispute the allegation and provide evidence of payment. HealthKeepers, Inc. will take the following actions in conjunction with the provider staff if patient pay remains unsatisfied after the first rounds of discussion or correspondence:

1. Convene a formal meeting with the nursing facility leadership and/or Commonwealth Coordinated Care Plus Waiver provider, member and/or responsible party, long-term care ombudsman/coordinated care advocates, Adult Protective Services representative, other representative of the state as applicable, and other parties key to the discussion.
2. Review the patient pay obligation and potential consequences of continued nonpayment.
3. Attempt to resolve the payment gap with a mutually agreed-upon plan.
4. Explain options if the member or responsible party wishes to pursue transfer to another facility or discharge to the community.
5. HealthKeepers, Inc., together with the provider, will engage in any of the following, as may be applicable if the patient pay continues to go unsatisfied:
    - Update and escalate intervention by Adult Protective Services or law enforcement.
    - Refer to state Medicaid Fraud Control Unit or other eligibility of fraud management staff the state may designate.
    - Escalate engagement to facilitate a change to representative payee, power of attorney or guardian.
    - Escalate appointment of a volunteer guardian or conservator.
    - Initiate discharge planning/transition to another provider.

Critical Incident Reporting and Management

HealthKeepers, Inc. has developed and implemented a Critical Incident Reporting and management system. Participating providers are required to participate in critical incident reporting. Immediate action will be taken to assure the member is protected from further harm. Critical incidents will be tracked and presented to our medical advisory committee and/or Quality Management committee for review if warranted.

A critical incident, also known as a major incident, includes but is not limited to:

- Medication errors
- Severe injury or fall
- Theft

- Suspected physical or mental abuse or neglect
- Financial exploitation
- Death of a member

Providers must report critical incidents to HealthKeepers, Inc. within 24 hours. The initial report of an incident within 24 hours may be submitted verbally, in which case the person, agency or entity making the initial report will submit a follow-up written report within 48 hours. Reports may be submitted to HealthKeepers, Inc. via email at CardinalCareCIs@anthem.com. Providers can find the Critical Incident Report Form on the provider website at **https://providers.anthem.com/va**. Providers can also call Provider Services at **800-901-0020**.

Suspected abuse, neglect and exploitation of members who are adults must be immediately reported. Suspected brutality, abuse or neglect of members who are children must also be immediately reported.

Reports of suspected child abuse and child dependent abuse must be made by calling the Virginia Child Protective Services hotline at **800-552-7096**. Reports of suspected adult and elderly abuse should be reported to the Virginia Adult Protective Services hotline at **888-832-3858**.

Providers must take steps within 24 hours to prevent further harm to any and all members and respond to any emergency needs of the member. Providers with a critical incident must conduct an internal critical incident investigation and submit an investigation report by the end of the next business day.

HealthKeepers, Inc. will review the provider's report and follow up with the provider as necessary to ensure that an appropriate investigation was conducted, and corrective actions were implemented within applicable time frames. Providers must cooperate with any investigation conducted by HealthKeepers, Inc. or outside agencies (for example, DMAS, Adult Protective Services, Child Protective Services and law enforcement).

CHAPTER 6: FOSTER CARE SPECIALTY PLAN

Overview

The Foster Care Specialty Plan is Virginia's Single Statewide specialty health plan for youth in foster care, youth who aged out of foster care (Former Foster care) and those receiving Adoption Assistance. HealthKeepers, Inc. was selected to implement the Foster Care Specialty plan, which is an addendum to the Cardinal Care Managed Care Contract, beginning July 1, 2025.

Summary

Each Foster Care Specialty plan member is assigned a regional care manager, which streamlines points of contact.

A dedicated Foster Care Specialty Plan Support Line is available Monday through Friday, 8 a.m. to 5 p.m. ET, where you can learn who the dedicated care manager is for a Foster Care Specialty Plan member.

HealthKeepers, Inc. has a dedicated Foster Care Specialty Plan team trained in trauma-informed care that supports the members, their caregivers, and liaises with the Department of Social Services.

HealthKeepers, Inc. offers exclusive value-added benefits and multiple programs that enhance the well-being of our FCSP members.

The League of Quality Providers (The League) is a model of provider engagement using the American Academy of Pediatrics Fostering Health Guidelines.

The League supports providers of all sizes to focus on the five domains that impact healthcare quality and outcomes for members in the child welfare system.

The Foster Care Specialty Plan offers support in Training

- The Provider Training Academy hosts Fostering Health: Standards of Care for Children in Foster Care developed by an AAP multidisciplinary panel of experts. This can be found under Training and Tutorials.
- Access to Training topics with CMEs is available
- Access to training platforms including Elsevier
- Sponsorship of evidence-based practices such as PCIT and TF-CBT
- Tools for understanding billing that supports engagement in patient care, beyond the exam room

CHAPTER 7: BEHAVIORAL HEALTH SERVICES

Overview

HealthKeepers, Inc. facilitates the integration of physical and behavioral health services as an essential part of whole healthcare. The mission is to offer mental health and substance use disorder education, a diverse range of targeted interventions and enhanced access to care to ensure improved outcomes and quality of life for members. HealthKeepers, Inc. works collaboratively with hospitals, residential facilities, group practices, independent behavioral health care providers, private community-based services agencies, Virginia's Community Services Boards, and other health-related social needs resources to successfully meet the behavioral health needs of members.

Goals

The goals of the behavioral health program are to:

- Ensure and expand service accessibility to eligible members.
- Promote the management and delivery of integrated physical and behavioral health services.
- Achieve quality initiatives including those related to HEDIS®, NCQA and Virginia DMAS performance requirements.
- Work with members, providers and community supports to provide recovery tools and create an environment that supports members' progress toward their recovery goals.
- Ensure utilization of the most appropriate, least restrictive and effective medical and behavioral health care in the right place, at the right time.

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

Objectives

The objectives of the behavioral health program are to:

- Promote continuity and coordination of care between physical and behavioral health care practitioners to assure a whole health approach to care.
- Enhance member satisfaction by facilitating providers' implementation of individualized and holistic support and care plans that support members in achieving their recovery goals.
- Provide members with education on treatment options and pathways toward recovery.
- Provide high-quality care management and care coordination services that identify member needs and address them in an individualized and holistic manner.
- Work with service providers to ensure the delivery of medically necessary and appropriate intervention, including inpatient, facility-based, community-based, and

outpatient clinic-based care at the least restrictive level possible in the member's community.

- Enhance provider satisfaction and success through collaborative and supportive relationships, built on mutually agreed upon goals, outcomes and incentives.
- Promote collaboration between all health care partners to achieve recovery goals through education, technological support and the promotion of recovery ideals.
- Use evidence-based guidelines and clinical criteria and promote their use in the provider community.
- Maintain compliance and accreditation standards with local, state and federal requirements.
- Ensure contracted providers deliver behavioral health and substance use disorder services in accordance with best practice guidelines, rules and regulations, and the policies and procedures set forth by the Commonwealth of Virginia.
- Promote the implementation of evidence-based practices at all levels of care through partnership with providers that includes incentivized outcomes.

Guiding Principles of the Behavioral Health Program

Recovery is a person-centered process in which people find their paths to participate fully in their communities through meaningful relationships, work and activities.

Resilience is the ability to live a fulfilling and productive life despite biological, behavioral, social and environmental challenges. Resilience is learned and developed; becoming resilient is a dynamic, progressive process that requires patience and effort to enhance positive responses to adverse circumstances. The goal is to nurture self-efficacy and confidence to accept and manage life's challenges, and experience optimism for personal successes.

Services delivered with a whole health orientation promote recovery and resilience by integrated goals and interventions that acknowledge the relationship between physical and mental health. Behavioral health services require effortful engagement with members that approaches their experiences and goals with respect, dignity, and hope for incremental change over time.

Ten fundamental components of recovery include:

1. **Self-direction:** Members lead, control and determine their own paths of recovery by optimizing autonomy, independence and control of resources to achieve a self-determined life.
2. **Individualized care:** There are multiple pathways to recovery based on an individual's unique strengths and resiliency, as well as an individual's needs, preferences and experiences including past trauma and cultural background.

3. **Empowerment:** Members have the authority to choose from a range of options and to participate in all decisions which will affect their lives, including the allocation of resources, and are educated and supported in so doing.
4. **Holistic:** Recovery embraces all aspects of life, including housing, employment, education, mental and physical health care treatment and services, complementary and naturalistic services (for example, recreational services, access to libraries, museums, etc.), addiction treatment, spirituality, creativity, social networks, community participation and family supports as determined by the member.
5. **Nonlinear:** Recovery is not a step-by-step process but one based on continual growth, occasional setbacks and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.
6. **Strengths-based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities and inherent worth of individuals.
7. **Peer support:** Mutual support, including the sharing of experiential knowledge, skills and social learning, plays an invaluable role in recovery.
8. **Respect:** Community, systems and societal acceptance and appreciation of consumers, including protecting their rights and eliminating discrimination and stigma, are crucial in achieving recovery.
9. **Responsibility:** Members have a personal responsibility for their own journeys of recovery and self-care.
10. **Hope:** Recovery provides the essential and motivating message of a better future — that people can and do overcome the obstacles that confront them. Hope is internalized but can be fostered by peers, family, friends, providers and others. Hope is the catalyst of the recovery process.

Systems of Care

Services provided to people with behavioral health issues and their families should be:

- **Person-centered:** The needs of the person should dictate the types and mix of services provided.
- **Inclusive:** The member's support system, including family, friends, peers and other people significant in the member's life, should be included whenever possible.
- **Community-based:** The focus of services, management and decision-making responsibility should rest at the community level.
- **Culturally congruent:** All involved agencies, programs and services should be responsive to the cultural, racial, gender and ethnic differences of the populations they serve.
- **Comprehensive:** An array of services that address physical, emotional, social, educational, behavioral, and cultural needs should be covered.

- **Personalized**: Services should meet members' unique needs and potential, as evidenced by the individualized service plan that is developed and formulated by the member with the assistance of professionals where needed.
- **Optimally delivered:** Services should be delivered in the least restrictive, most normative environment that is clinically appropriate.
- **Integrated**: Services should be integrated and coordinated between agencies and include mechanisms for planning, developing and coordinating services inclusive of case management/care coordination or similar mechanisms. This ensures multiple services are delivered in a coordinated, therapeutic manner and adapted in accordance with the changing needs of the person and their support system.
- **Nondiscriminatory:** Services should be delivered without regard to race, religion, national origin, gender, physical ability, gender orientation or other characteristics.
- **Oriented to recovery and independence**: Services should be flexible and evolve over time.
- **Effective:** Services should assist the person in achieving the life they envision for themselves.

Coordination of Behavioral Health and Physical Health Treatment

Participating providers are encouraged to notify a member's PCP when a member with behavioral health issues first enters behavioral health care and anytime there is a significant change in care, including treatment, medications or need for medical services. Providers should remain in contact with the PCP regarding any changes in physical or behavioral health care and to work collaboratively to better serve the needs of the member. Key elements of the model for coordinated and integrated physical and behavioral health services include:

- Ongoing communication and coordination between PCPs and specialty providers, including mental health and substance use disorder providers;
- Screening by PCPs for behavioral health, substance use and co-occurring disorders and referral to trusted providers;
- Development of person-centered treatment plans primarily driven by members and involving providers and significant people in the member's support system;
- Care management/care coordination programs to support the coordination and integration of care between providers.

Fostering a culture of collaboration and cooperation helps sustain a seamless continuum of care between physical and behavioral health and positively impacts member outcomes. Communication between the member, his or her support systems, and behavioral health and/or physical care providers is critical, especially for members who are simultaneously utilizing physical health, behavioral health and pharmacy services.

Provider Roles and Responsibilities

Behavioral health care benefits are carefully integrated into all healthcare programs. This coordination of healthcare resources requires certain roles and responsibilities for behavioral health providers, including:

- Participation in the care management and coordination process for each Anthem HealthKeepers Plus member within your care.
- Submission of appropriate materials to obtain pre-authorization for all relevant services through the appropriate website or fax, and efficient responsiveness to requests for additional clinical information.
- Provision of a summary of the member's initial assessment, primary and secondary diagnosis and prescribed medication to the PCP.
- Provision of, at a minimum, a summary of the findings from the member's initial visit to the PCP. This notification should include the behavioral health provider's contact information, visit date, presenting problem, diagnosis and a list of any medications prescribed.
- Notification to the member's PCP of any significant changes in the member's status and/or change in the level of care.
- Ensure that members receiving inpatient psychiatric services are scheduled for an outpatient follow-up and/or continuing treatment prior to discharge. This treatment should be provided within seven-calendar days from the date of the member's discharge.
- Offer hours of operation that are no less than the hours of operation offered to commercial members.
- Encourage members to consent to sharing substance use disorder treatment information.

Transition after Acute Psychiatric Care

To assist in the transition from an acute psychiatric facility to home or an alternative setting, HealthKeepers, Inc. recommends scheduling a transition appointment. A licensed behavioral health practitioner should conduct this session, ideally taking place before the member actually leaves the facility. If this is not possible, the appointment should occur as soon after discharge as possible – preferably within the National Committee for Quality Assurance's seven-day recommendation. HealthKeepers, Inc. assigns at least one Transitional Care Coordinator to each region to support this process for members and their connections with providers. These Transitional Care Coordinators work with each acute psychiatric facility within their region to coordinate discharge plans and assure a seamless plan of care as the member returns to their community.

Provider Success

HealthKeepers, Inc. believes provider success is necessary to achieve health goals and is committed to supporting and working with qualified providers to ensure that optimal recovery goals are met. HealthKeepers, Inc.'s commitment includes:

- Improving communication of the clinical aspects of behavioral health care to improve outcomes and recovery;
- Supporting providers in delivering integrated, coordinated physical and behavioral health services to meet the needs of the whole person;
- Simplifying pre-authorization rules, referrals, claims and payment processes to help providers reduce administrative time and focus on the needs of members. Providers should submit all Behavioral Health Authorization requests through Availity Essentials.

Health Plan Clinical Staff

All clinical staff at the health plan are licensed and have prior clinical experience. The Anthem HealthKeepers Plus Medical Director is board-certified in Psychiatry and licensed in the Commonwealth of Virginia. The Anthem HealthKeepers Plus Behavioral Health Clinical Director is a Licensed Mental Health Provider in the Commonwealth of Virginia. The highly trained and experienced team of clinical care managers, care coordinators, peer recovery specialists, and support staff provides high-quality care management and care coordination services to members and strives to work collaboratively with all providers.

Traditional and Nontraditional Behavioral Health Service Categories

HealthKeepers, Inc. covers Behavioral Health Services, which includes inpatient and outpatient (individual, family and group) therapies, community-based services, facility/clinic-based services, crisis services, and services delivered under a temporary detention and/or emergency custody order.

Traditional Behavioral Health Services

HealthKeepers, Inc. covers all of the following traditional behavioral health and substance use disorder treatment services.

Inpatient behavioral health services: Inpatient psychiatric services in a psychiatric unit of a general acute care hospital are covered for all eligible members regardless of age. Medically necessary services in free-standing psychiatric hospitals (IMDs) are covered for members under 21 and over 64. For members aged 21-64, coverage in IMDs as "in lieu of" services is permissible if it meets specific criteria under 42 CFR § 438.3(e)(2). Temporary Detention Orders (TDOs) must be processed through the state TDO program for relevant age groups, while MCOs manage continued care post-TDO discharge.

All inpatient mental health admissions must be approved by HealthKeepers, Inc. using medical necessity service authorization criteria.

Outpatient behavioral health and substance use treatment services (traditional individual, family, and group therapies): HealthKeepers, Inc. provides coverage for medically necessary outpatient individual, family, and group behavioral health and substance use disorder treatment services for children, adolescents, and adults. This includes brief screenings, psychological and neuropsychological testing, and health and behavior assessment/interventions. Per state requirements and mental health parity, these services do not require pre-authorization.

Temporary Detention Order (TDO) services: HealthKeepers, Inc. provides payment of behavioral health services rendered as a result of a TDO. HealthKeepers, Inc. is responsible for all TDO admissions to an acute care facility, regardless of age. DMAS assumes medical necessity is established, and HealthKeepers, Inc. **does** not withhold or limit services specified in a TDO. Services such as an acute inpatient admission will not be denied based on a diagnosis while the client is under TDO . During a TDO, a psychiatric evaluation for mental disorder or disease will occur. An individual under TDO may be **provided services in a private or** public facility certified by DMAS for behavioral health and developmental services, or in a Crisis Receiving Center or Residential Crisis Stabilization Unit. The duration of temporary detention shall be in accordance with the code of Virginia, as follows:

> ***For Individuals under age eighteen (18) (Minors):*** *Pursuant to § 16.1-340.1.G of the Code of Virginia, the duration of temporary detention must be sufficient to allow for completion of the examination required by § 16.1-342, preparation of the preadmission screening report required by § 16.1-340.4, and initiation of mental health treatment to stabilize the minor's psychiatric condition to avoid involuntary commitment where possible, but must not exceed ninety-six (96) hours prior to a hearing. If the ninety-six (96)-hour period herein specified terminates on a Saturday, Sunday, or Legal Holiday, the minor may be detained, as herein provided, until the close of business on the next day that is not a Saturday, Sunday, or Legal Holiday. The minor may be released, pursuant to § 16.1-340.3, before the ninety-six (96)-hour period herein specified has run.*
>
> ***For Adults age eighteen (18) and over:*** *Pursuant to § 37.2-809.H of the Code of Virginia, the duration of temporary detention must be sufficient to allow for completion of the examination required by § 37.2-815, preparation of the preadmission screening report required by § 37.2-816, and initiation of mental health treatment to stabilize the person's psychiatric condition to avoid involuntary commitment where possible, but must not exceed seventy-two (72) hours prior to a*

hearing. If the seventy-two (72)-hour period herein specified terminates on a Saturday, Sunday, Legal Holiday, or day on which the court is lawfully closed, the person may be detained, as herein provided, until the close of business on the next day that is not a Saturday, Sunday, Legal Holiday, or day on which the court is lawfully closed. The person may be released, pursuant to § 37.2-813, before the seventy-two (72)-hour period herein specified has run.

Coverage for services for Members admitted to a freestanding psychiatric facility under a TDO shall be handled as follows:

If the Member is under age 21 or over age 64 and goes into a private freestanding IMD or a State freestanding IMD for a TDO, HealthKeepers, Inc. is responsible for the TDO. If the Member remains in the IMD after the TDO expires and continues to meet medical necessity criteria for admission, HealthKeepers, Inc. is responsible for payment of the psychiatric stay. Following expiration of the TDO, HealthKeepers, Inc. can require that the Member transfer to a different in-network facility.

For Members ages 21 through 64 admitted into a private freestanding IMD or a State freestanding IMD for a TDO, providers should submit the TDO claim to the state TDO program. Do not submit the request for prior authorization for the TDO to HealthKeepers, Inc. The Member will remain enrolled with HealthKeepers, Inc. beyond the TDO timeframe. HealthKeepers, Inc. will manage the Member's treatment needs beyond the TDO timeframe and can require that the Member transfer to an in-network facility at the end of the TDO timeframe.

When an out-of-network provider provides services for a member under a TDO, HealthKeepers, Inc. is responsible for reimbursement of these services. In the absence of an agreement otherwise, all claims for TDO service shall be reimbursed at the applicable Medicaid fee-for-service rate in effect at the time the service was rendered.

Following the expiration of the TDO, if the judge determines the member may be transferred without medically harmful consequences, HealthKeepers, Inc. may designate an appropriate in-network or out-of-network facility for the provision of care. After the TDO, HealthKeepers, Inc. will conduct a utilization review for medical necessity to determine if continued, acute care stay criteria for behavioral health services is appropriate. HealthKeepers, Inc. shall cover TDO in accordance with Medicaid timely filing requirements – one year from the date of the TDO.

In the event that an Anthem HealthKeepers Plus member between the ages of 21 and 64 is admitted to a freestanding psychiatric facility under a TDO, HealthKeepers, Inc. is responsible for reimbursing transportation to the facility.

FAMIS exception: HealthKeepers, Inc. does not cover inpatient psychiatric treatment as a result of a TDO outside of the coverage guidelines described for inpatient behavioral health services. Coverage TDO admissions may be available through the state TDO program.

Emergency custody orders: HealthKeepers, Inc. is responsible for coverage of medically necessary screenings, assessments and treatment, as covered under this manual, for members who are under an emergency custody order.

Nontraditional Behavioral Health Services
All "non-traditional" behavioral health services require either prior registration or authorization as specified in the DMAS policy manuals. Providers should use the approved DMAS forms to seek registration and authorization. These service authorization forms are located at the following site
https://providers.anthem.com/virginia-provider/resources/forms

Nontraditional Behavioral Health Service Authorizations
The preferred method of submission for authorization requests is only through Availity Essentials.

If unable to submit through Availity Essentials, please use the expedited fax line **844-445-6646** for all ARTS, Inpatient Psychiatric Hospitalization, Mental Health Intensive Outpatient Program, Mental Health Partial Hospitalization Program, Community Stabilization, Mobile Crisis Response, 23-hour Crisis Stabilization, and Residential Crisis Stabilization authorization requests. For all other Behavioral Health outpatient service authorization requests, please use the standard fax line **844-445-6642**.

The "non-traditional" services are categorized by level of care and include the following:

- Targeted Case Management
- Community Mental Health and Rehabilitation Services
  - Therapeutic Day Treatment
  - Intensive In-Home Services
  - Mental Health Skill Building
  - Psychosocial Rehabilitation
- Comprehensive Crisis and Transition Services
  - Mobile Crisis Response
  - Community Stabilization
  - 23-Hour Crisis Stabilization (Crisis Receiving Center)
  - Residential Crisis Stabilization Unit
- Community-Based Services
  - Assertive Community Treatment

  - Multisystemic Therapy
  - Functional Family Therapy
  - Applied Behavioral Analysis
  - Peer Recovery Support Services
- Facility-Based Services
  - Mental Health Partial Hospitalization Programs
  - Mental Health Intensive Outpatient Programs

Clinical trials as EPSDT: Clinical trials are considered under EPSDT when no acceptable or effective standard treatment is available for the child's medical condition. The treatment must be evaluated on a case-by-case basis using EPSDT criteria. Routine patient costs furnished in connection with a member's participation in a qualifying clinical trial are covered even when it is not covered under EPSDT.

Addiction and Recovery Treatment Services (ARTS)

HealthKeepers, Inc. is committed to integrating physical and behavioral health care services to improve health outcomes and reduce costs for addiction and recovery treatment services. To fully integrate physical and behavioral health services for individuals with substance use disorder (SUD) and expand access to the full continuum of services, DMAS implemented the ARTS benefit and delivery systems for individuals with an SUD. These services include the following:

- Medically Managed Inpatient Services
- Medically Monitored High Intensity Inpatient Services
- Medication-assisted treatment (opioid treatment)
- Methadone treatment
- Substance Use partial hospitalization
- Clinically managed Residential Services
- Clinically Managed Low-intensity Residential Services
- Substance Use intensive outpatient program
- Substance Use case management/care coordination
- Substance Use peer recovery support services

ARTS Service Authorization

HealthKeepers, Inc. will respond to the provider's service authorization submission via the ARTS Service Authorization Review Form with the results of HealthKeepers, Inc.'s independent assessment within seventy-two (72) hours for ASAM levels 2.1, 2.5, 3.1, 3.3, 3.5, 3.7, and 4.0, . It is critical that providers use the service authorization template created by DMAS and available at the following links:

https://providers.anthem.com/virginia-provider/resources/forms

https://www.dmas.virginia.gov/for-providers/benefits-services-for-providers/behavioral-health/addiction-and-recovery-treatment-services/authorization-and-registration/

EPSDT

In addition to the traditional review for medical necessity, service authorization requests for Medicaid Members under age twenty-one (21) that do not meet general coverage criteria are reviewed under EPSDT criteria. Denial for services to individuals under age twenty-one (21) are not given until the EPSDT secondary review has been completed. Providers to contact Care Coordinators or Care Managers to explore alternative services, therapies, and resources for Members. Our obligation at HealthKeepers, Inc. is to ensure that care coordination is provided and referrals are made to other clinically appropriate services.

Behavioral Health Care Management/Care Coordination

Care management/care coordination is a continuum of service and support that is matched on an individualized basis to the needs of the member. Behavioral health care management/care coordination programs are designed to improve member health outcomes by integrating with Anthem HealthKeepers Plus physical healthcare programs. Behavioral Health Transitional Care Coordinators are present in each region and support outreach, engagement, and discharge planning for members who are admitted for psychiatric hospitalization or are known to be in Emergency Rooms.

Providers are encouraged to collaborate and engage with the care managers/care coordinators as well as provide feedback to members' care plans.

Clinical teams are staffed with Virginia-based behavioral health and medical care managers/care coordinators working in close collaboration with community, community service board and Department of Social Services case managers. The main functions of the behavioral health case managers/care coordinators include but are not limited to:

- Use health-risk appraisal (HRA) data gathered from members upon enrollment to identify members who will benefit from engagement in individualized care coordination and case management.
- Consult and collaborate with medical case managers/care coordinators and condition care clinicians regarding members who present with comorbid conditions. Comorbid means either the presence of one or more disorders (or diseases) in addition to a primary disease or disorder, or the effect of such additional disorders or diseases.
- Refer members to appropriate providers and continue involvement to coordinate care among different agencies, medical providers, etc.
- Work directly with the member and provider based upon the severity of the member's condition.

- Ensure accurate and complete reporting by documenting all actions taken and outcomes achieved in the Anthem HealthKeepers Plus information system.

Member Record Documentation and Treatment Planning

Comprehensive Assessment

Information related to the provision of appropriate services to a member must be included in the member record. There should also be documentation in a prominent place about whether there is an executed declaration for behavioral health treatment. These requirements permit effective service provision and quality reviews.

Medical record documentation must:

- Reflect who rendered what service, why, when and to whom
- Be legible and signed by the person providing the service (Legible documentation is required to substantiate reimbursement for services.)
- Be complete (including positive as well as negative findings)
- Be recorded in a timely manner
- Reflect the coded service identifiers or successor codes reported on the health insurance claim form
- Be maintained for five years for audit purposes

A progress note is generated and documented after each covered individual contact. HealthKeepers, Inc. reserves the right to retract or recover any payments made when there is an absence of documentation, illegible documentation, or if documentation is insufficient to justify services billed, subject to all restrictions of applicable law.

Personalized Support and Care Plan

A patient-centered support and care plan based on the behavioral health, medical, substance use and community functioning needs of the member based on the initial assessment should be completed in collaboration with any member who receives services. There must be documentation in every case that the member and, as appropriate, his or her support system participated in the development and subsequent reviews of the treatment plan. A provider who discovers a gap in care is responsible to help the member get that gap in care fulfilled; documentation should reflect the action taken.

The treatment/support/care plan should contain the following elements:

- Problem(s) for which the member is seeking treatment
- Member goals related to each problem(s) identified, written in member-friendly language
- Measurable objectives to address the goals identified
- Target dates for completion of objectives
- Responsible parties for each objective

- Specific measurable action steps to accomplish each objective
- Actions agreed to be taken when progress toward goals is less than originally planned by the member and provider
- Individualized steps for prevention and/or resolution of crisis
- This includes 1) identification of crisis triggers (situations, signs and increased symptoms), 2) active steps or self-help methods to prevent, de-escalate or defuse crisis situations, 3) names and phone numbers of contacts who can assist the member in resolving a crisis and 4) the member's preferred treatment options, to include psychopharmacology, in the event of a mental health crisis.

Inpatient Documentation Guidelines

Sufficient documentation in the medical record is required to enable Utilization Review staff to determine medical necessity, quality of care and appropriateness of treatment. Documentation is also required to verify services performed, for the purpose of determining coverage and reimbursement.

Covered individuals within a facility setting must be under the medical supervision of a physician. The attending physician maintains responsibility for the total care of the covered individual. Although members of other disciplines write psychotherapy notes, the physician of record has the responsibility to document the medical necessity for the prescribed psychotherapy and the total treatment program. Evaluations, assessments, and other services must be made by credentialed and/or licensed professional staff according to facility policy and professional standards.

I. **Admission note:** Within 24 hours of admission, the attending physician and the nurse performing the initial assessments must personally document their findings in the medical record. Documentation must include the time the assessment was performed by the attending physician.
    a. Documentation of the severity of the presenting problem must support the medical necessity of inpatient admission.
    b. The primary ICD-10 diagnosis must be documented by the physician and must be consistent with the presenting problem.
        i. The covered individual's potential for danger to self, others and/or property must be clearly documented. Documentation must indicate the presenting thoughts, intent, plan and method.
    c. An initial diagnostic evaluation must be documented and include the following:
        i. Date of exam
        ii. Presenting problem, including supporting signs and symptoms
        iii. History of present illness
        iv. Previous treatment and outcome
        v. Medical history, including medications and allergies
        vi. Social history/family history
        vii. History of alcohol and drug use

viii. Mental status exam
ix. Diagnosis

d. An initial treatment plan, including the goals for hospitalization, must be documented, including an estimated length of stay (LOS) and the initial discharge plan.
e. Signatures and credentials are required documentation for the attending physician and all licensed staff.

II. **History and physical:** Within 24 hours of admission a history and physical (H&P) must be completed by a licensed physician, or a nurse practitioner under the supervision of a licensed physician, and documented in the medical record. The H&P must evaluate the individual's physical and medical stability for treatment in an inpatient setting. An explanation of exceptions for any H&P component must be documented.

a. H&P documentation is to include an evaluation of the following:
    i. General appearance and nutritional status
    ii. Skin and lymph
    iii. Head and neck
    iv. Eyes/vision
    v. Ears/hearing
    vi. Nose
    vii. Mouth and throat
    viii. Chest and lungs
    ix. Breast
    x. Heart
    xi. Abdomen
    xii. Genitalia
    xiii. Rectal
    xiv. Bones, joints and muscles
    xv. Neurological, including:
        1. Motor
        2. Sensory
        3. Cranial nerves
        4. Deep tendon reflexes
        5. Strength
        6. Cerebrum
        7. Posture and gait
    xvi. Clinical impression, to include activity level
b. Signature and credentials of the physician are required.
c. Laboratory results must be documented in a timely manner.

III. **Consultation services:** A consultation is the rendering of an expert opinion, in relation to the diagnosis or treatment of an illness or injury by a provider other than the attending physician. The provider must be qualified by training and experience to render an expert opinion in a given specialty.

a. The attending physician must order the consultation, and the provider who renders it must include a written report in the medical record.
b. All consultations must be performed by the provider billing for the service. Benefits are not provided for telephone consultations.

IV. Master treatment plan: A master treatment plan that addresses measurable goals and objectives relating to the presenting problems and defines realistic goals for discharge must be documented in the medical record within three days.

a. All therapies and disciplines involved must be addressed in the master treatment plan.
b. The covered individual's strengths and weaknesses and the ability to reach realistic goals must also be documented.
c. The treatment plan must be current and updated at least every seven days.
d. Discharge planning must be documented in the treatment plan.
e. Specific follow-up plans for post discharge must be documented.
f. Psychological testing required for differential diagnosis and the development of a treatment plan should be ordered within days of admission. Results should be documented in the medical record within three days of completed testing.

V. Progress notes: Documentation in the progress notes is required to address the member's response to treatment. After significant patient contact, all disciplines must record their assessment in the medical record. All entries must be dated and signed by each professional, noting their credentials.

a. Interventions, goals of the master treatment plan and coordination of services must be substantiated.
b. An explanation of positive or negative change in the member's condition is required.
c. Deterioration or complication following initiation or change of medication must be documented.
d. Ongoing documentation of the member's mental, functional and medical stress is required.
e. The member’s response to treatment must be documented.
f. A record of the use of any physical and/or chemical restraints or seclusion must be documented.
g. The medical record must reflect daily medical and nursing documentation of the severity of illness and intensity of services rendered, and a daily progress note documented by the psychiatrist.

VI. Psychotherapy: Documentation of psychotherapy sessions is required in the medical record to determine that the services were rendered and medically necessary. The documentation must be written directly by the provider or dictated by the provider.

a. The licensed provider must personally render all psychotherapy billed to HealthKeepers, Inc. While there may be useful therapy groups run by

personnel who are not licensed mental health professionals (for example, in Intensive Outpatient or Partial Hospitalization programs), these therapy groups are included in the rate for these services and will not be reimbursed separately by HealthKeepers, Inc.

b. Patient interactions of less than 20 minutes in duration may be documented as medication evaluation, but may not be documented as psychotherapy sessions.
c. For utilization review purposes and to qualify for reimbursement, one note for each psychotherapy session is required. The psychotherapy note must indicate the following information:
    i. Date of service
    ii. Length of session (start and end times)
    iii. Statement of therapeutic focus, including the therapist's interventions
    iv. Periodic reference to the patient's progress
    v. Individuals present at the session
d. A separate note must be written in the facility record for each patient in group therapy, indicating the nature of the participation at each session.

Outpatient Documentation Guidelines

A clinical record is required for all office psychotherapeutic services. Sufficient documentation is required to determine medical necessity, quality of care and appropriateness of treatment. Documentation is also required to verify services performed for the purpose of determining coverage and reimbursement. The provider must personally render all psychotherapy billed to HealthKeepers, Inc.

I. **Clinical evaluation:** A clinical evaluation must be documented in the medical record. Documentation must include:
    a. The presenting problem, including:
        i. History of present illness
        ii. Evidence of personal distress
        iii. Impairment of functioning
    b. Medical history, including medication and allergies
    c. Previous treatment and outcome
    d. Social history/family history
    e. History of alcohol and drug use
    f. Mental status exam
    g. Appropriate diagnosis
    h. Initial treatment plan, including:
        i. Goals of treatment
        ii. Estimated number of treatment sessions to achieve goals
    i. Signature and credentials of provider

II. **Psychotherapy notes:** Patient interactions of less than 20 minutes in duration may be documented as medication evaluation, but may not be documented as psychotherapy sessions. The use of code 90837 requires at least 53 minutes of direct face-to-face contact.
   a. Clinical notes must be documented in a timely manner and include:
      i. Patient's name
      ii. Date of service
      iii. Type and length of session
      iv. Individuals present at the session
      v. Current symptoms
      vi. Current level of functioning
      vii. Focus of session, including the therapist's intervention(s)
      viii. Future directions
      ix. Next scheduled appointment
      x. Summary of treatment outcome upon termination
   b. A separate note is written in the medical record for each patient in group therapy, indicating the nature of the participation at each session.
   c. Signature and credentials of provider after each session

Psychotropic Medications

Prescribing providers must inform all members considered for prescription of psychotropic medications of the benefits, risks and side effects of the medication, as well as alternate medications and other forms of treatment.

If obesity is also a problem, the medical record needs to reflect that a healthy diet and exercise plan has been prepared and given to the member or, if appropriate, a referral to a nutritionist or obesity medical professional.

If diabetes is a problem, the medical record needs to reflect a discussion with the member about their condition. Their treating provider and coordination efforts with that provider should be identified in the documentation as well. The medical record is expected to reflect such conversations as having occurred, and indicate that prescription data has been shared with the member's PCP.

Members on psychotropic medications may be at an increased risk for various disorders. It's expected that providers are knowledgeable, regularly inquire about and look for side effects and risks of medications. This especially includes:

- Follow-up to inquire about suicidality or self-harm in children, adolescents and young adults placed on antidepressant medications, as per Food and Drug Administration and American Psychiatric Association guidelines
- Regular and frequent weight checks and measurement of abdominal girth, especially for those on antipsychotics or mood stabilizers

- Glucose tolerance test or hemoglobin A-1C tests, especially for those members on antipsychotics or mood stabilizers
- Triglyceride and cholesterol checks, especially for those members on antipsychotics and mood stabilizers
- Electrocardiogram (ECG) checks for members placed on medications with risk for significant QT-prolongation
- Ongoing checks for movement disorders related to antipsychotic use and psychotic disorders.

Guidelines for such testing and follow-up are provided by the American Psychiatric Association, among others. Summary guidelines are referenced on the provider website at **https://providers.anthem.com/va**. While the prescriber is not expected to personally conduct all of these tests, the prescriber is expected to ensure these tests occur where indicated and to initiate appropriate interventions to address any adverse results. These tests and the interventions must be documented in the member's medical record.

Utilization Management

Utilization Management (UM) decisions are governed by the following statements:

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

UM guidelines can be found on the provider website at **https://providers.anthem.com/va**.

Access to Care Standards

The standards for timely and appropriate access to quality behavioral health care are:

1. Emergent: immediately
2. Emergent (not life-threatening/crisis stabilization): within 24 hours of request
3. Urgent: within 48 hours of referral/request
4. Routine outpatient: within five days of request
5. Outpatient following inpatient hospital discharge: within seven days of discharge

Definitions

Emergent: Treatment is considered to be an on-demand service and does not require prior authorization. Members are asked to go directly to emergency rooms for services if they are either unsafe or their conditions are deteriorating.

Urgent: A service need that is not emergent and can be met by providing an assessment and services within 48 hours of the initial contact (for example, if a member is pregnant and has substance use problems).

Routine: A service need that is not urgent, and can be met by receiving treatment within five days of the assessment without deterioration in the individual's functioning or worsening of his or her condition.

Preauthorization and Notification

Standard authorization decisions are made within seven calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days if 1) the member or the provider requests an extension, or 2) there is a need for additional information.

Expedited / urgent authorization decisions are made within 72 hours and are for cases in which a provider indicates, or HealthKeepers, Inc. determines, that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. HealthKeepers, Inc. will make an authorization decision and provide notice as expeditiously as the member's health condition requires and no later than seventy-two hours (three calendar days) after receipt of the request for service.

HealthKeepers, Inc. may extend the 72-hour turnaround time frame by up to 14 calendar days if 1) the member requests an extension, or 2) there is a need for additional information.

How to Provide Notification/Request Pre-Authorization

All facility-based behavioral health and substance use services require pre-authorization, with the exception of temporary detention orders (TDOs). TDOs require notification and authorization for continued stay after the expiration of the TDO.

When providing notification or requesting prior authorization for behavioral health services, it is preferred that providers please use Availity Essentials (**https://Availity.com**). Using the website is the most efficient way to get the authorization completed, and provides a means for providers to communicate with UM reviewers.

If you prefer to call or fax, please see the below contact information:

- Anthem HealthKeepers Plus inpatient prior authorization phone: **800-901-0020**
- Please use the template pre-authorization forms in their original formatting. There are two separate fax lines depending on the service one is requesting. Please see

below for a chart of which preauthorization form for which services should be faxed to which number.

844-445-6642 **Mental health services** **(Standard Authorization = 7 days)**	**844-445-6646** **Addiction and Recovery Treatment Services (ARTS) services, acute facility services, crisis services** **(Urgent Authorization = 72 hours)**
Therapeutic Day Treatment Intensive In Home Psychosocial Rehabilitation Mental Health Skill Building Multisystemic Therapy Functional Family Therapy Assertive Community Treatment Mental Health Case Management Mental Health Peer Recovery Support Services Applied Behavioral Analysis Out of Network Outpatient Psychiatric Services	Psychiatric Hospitalization Mental Health Intensive Outpatient Services Mental Health Partial Hospitalization Inpatient Withdrawal Management Substance Use Partial Hospitalization Substance Use Intensive Outpatient Services Substance Use Residential Treatment Substance Use Case Management/Care Coordination Substance Use Peer Recovery Support Services Mobile Crisis Response Community Stabilization 23 Hour Stabilization / Crisis Receiving Center Residential Crisis Stabilization Unit

Medical Necessity Determination and Peer Review

- When a provider requests initial or continued preauthorization for a covered service, utilization managers review the necessary clinical information to determine if the request meets applicable medical necessity criteria.
- If the information submitted does not appear to meet such criteria, the utilization manager submits the information to the medical director or other appropriate practitioner for review, as part of the peer review process.
- Only the attending physician may initiate a peer-to-peer conversation to discuss the relevant clinical information with the clinician working with the member.
- If an adverse decision is made by the reviewer without a peer-to-peer conversation (as may occur when the provider is unavailable for review), the attending physician may request such a conversation. In this case, HealthKeepers, Inc. will ensure a medical director or other appropriate practitioner is available to discuss the case with the provider. This conversation may result in the decision being upheld or changed.

- Members, providers, and applicable facilities are notified of any adverse decision within notification time frames. These time frames are based on the type of care requested and are in conformance with regulatory and accreditation requirements.

Adverse Decisions, Appeals, Grievances and Payment Disputes

If a provider received an administrative adverse decision or did not receive prior authorization for a requested service and thinks the decision was in error, they may refer to the **Grievances and Appeals** chapter for information and instructions about grievances and medical necessity appeals, and refer to the **Claims and Billing** chapter for payment disputes.

Avoiding an Adverse Decision

Most administrative adverse decisions result from nonadherence to, or a misunderstanding about, utilization management policies. Familiarizing yourself and your staff with notification and prior authorization policies can eliminate the majority of these decisions. Other administrative adverse decisions result from misinformation about the member's status or benefits. Such information is readily available by calling **800-901-0020.**

Adverse decisions of a medical nature are rare. Such adverse decisions usually involve failure of the clinical information to meet evidenced-based national guidelines. HealthKeepers, Inc. is committed to working with all providers to ensure that such guidelines are understood and easily identifiable for providers. A peer-to-peer conversation between a medical director and clinician(s) is one way to ensure the completeness and accuracy of the clinical information.

Medical record reviews are another way to ensure that clinical information is complete and accurate. Providers who can appropriately respond in a timely fashion to peer-peer and medical record requests are less likely to encounter dissatisfaction with the utilization management process. HealthKeepers, Inc. is committed to ensuring a process that is quick, easy and mutually beneficial.

Clinical Practice Guidelines

All providers have access to evidence-based Clinical Practice Guidelines for a variety of behavioral health disorders commonly seen in primary care, including ADHD, bipolar disorder for children and adults, major depressive disorder, schizophrenia and substance use disorders. These Clinical Practice Guidelines are located on the provider website at **https://providers.anthem.com/virginia-provider/resources/manuals-and-guides**

Emergency Behavioral Health Services

Providers should immediately refer any member who is in crisis or who is a threat to self or others for emergency care, preferably by calling 988. An emergency referral for behavioral health services does not require prior authorization or admission review.

Behavioral Health Self-Referrals

Members may self-refer to any behavioral health care provider in the Anthem HealthKeepers Plus network. If the member is unable or unwilling to access timely services through community providers, call Anthem HealthKeepers Plus Provider Services at **800-901-0020** for assistance.

Behavioral Health Services

PCPs may treat members with situational behavioral health disorders, the most common of which are depression and anxiety. PCPs are required to refer members who are experiencing acute symptoms of a chronic behavioral health disorder, exhibiting an acute onset of symptoms, or are in a crisis state. PCPs can go online to the provider website at **https://providers.anthem.com/va** for details about covered services.

PCPs are also required to make referrals for members whose symptoms of anxiety and mild depression persist or become worse. Any member suspected of developing toxicities to medications that have been prescribed by a psychiatrist will need to be referred back to the behavioral health system for observation and medication monitoring.

PCPs should refer any member with an established diagnosis or suspected onset of symptoms indicative of behavioral health disorders to a behavioral health services provider.

Links to Forms, Guidelines and Screening Tools

Behavioral health forms:
https://providers.anthem.com/virginia-provider/resources/forms > Forms > Behavioral Health

Services requiring prior authorization: **https://providers.anthem.com/va** > **Prior authorization** > **How to Request Prior authorization**

Screening tools for PCPs and behavioral health providers:
https://providers.anthem.com/va > **Provider Education > Manuals, Directories, Training & More >** Anthem HealthKeepers Plus Directories, Training & Resources

Clinical Practice Guidelines (CPGs) for medical providers:
https://providers.anthem.com/virginia-provider/resources/manuals-and-guides

CHAPTER 8: MEMBER ELIGIBILITY

Overview

Given the increasing complexities of healthcare administration, widespread potential for fraud and abuse, and constant fluctuations in programs, Anthem HealthKeepers Plus providers need to be vigilant about member eligibility. Eligibility should be verified before each time services are rendered.

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. Because eligibility can change, it should be verified at every visit. Remember that claims submitted for noneligible members will not be eligible for payment.

How to Verify Member Eligibility

Providers can verify member eligibility in several ways:

- Log in to the Virginia Medicaid Web Portal at: **https://vamedicaid.dmas.virginia.gov/**
- Call the DMAS automated response system (ARS) at **800-884-9730** or **800-7729-996**.
- Log in to **https://Availity.com**
- Contact Anthem HealthKeepers Plus Provider Services at **800-901-0020**

In addition to the member's Medicaid ID, providers need one of the following combinations to access either ARS or the website:

- Member Social Security number (SSN) and date of birth
- Member SSN and member name (first and last name)
- Member date of birth and member name (first and last name)

Member Copays

Anthem HealthKeepers Plus members do not have copays.

Member ID Cards

Once enrolled, members will receive a Medicaid ID card from DMAS and a member ID card from HealthKeepers, Inc. 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.

The Anthem HealthKeepers Plus ID card (for Cardinal Care Managed Care and FAMIS members) includes the following member information:

- Name

- Date of birth
- Anthem HealthKeepers Plus ID number
- Medicaid ID number
- Member copay responsibility ($0 as applicable)
- Name of the member's PCP
- Pharmacy processing instructions (RX group number, PCN and RX BIN number)
- Behavioral health and ARTS crisis phone number
- Emergency instructions
- Dental contact information
- Transportation contact information
- Information needed to process claims

If a card is lost, members may receive replacement cards by calling 800-901-0020.

CHAPTER 9: UTILIZATION MANAGEMENT

Overview

Utilization management (UM) is a cooperative effort with providers to promote, provide and document the appropriate use of quality healthcare resources. The goal is to provide the member with access to the right care, at the right time and in the appropriate setting.

The Anthem HealthKeepers Plus decision-making process reflects the most up-to-date UM standards from the National Committee for Quality Assurance. The UM team takes a multidisciplinary approach to meet members' medical and psychosocial needs.

The following criteria are used when making UM decisions:

- Federal and state mandates
- Member benefits
- Clinical program guidelines
- Clinical Utilization Management Guidelines
- MCG (formerly Milliman Care Guidelines)
- HealthKeepers, Inc. policies and procedures
- HealthKeepers, Inc. behavioral health medical necessity criteria
- Carelon Medical Benefits Management guidelines

Staff Availability

UM staff is available Monday through Friday, from 8:30 a.m. to 5 p.m. ET, to answer UM related questions for both members and providers.

After regular business hours, an answering service is available to take UM-related messages. HealthKeepers, Inc. is available 24/7 for participating providers who need authorizations for post stabilization medical admissions or behavioral health care.

The UM staff member will identify him/herself by first name/last name initial, title and organization when initiating, answering or returning calls regarding UM issues.

Decision Criteria

The decision-making criteria used by the UM team are evidence-based and consensus-driven. HealthKeepers, Inc. periodically updates criteria and policy as standards of practice and technology change. HealthKeepers, Inc. involves practicing physicians in these updates and notifies providers of changes through provider bulletins. The UM team provides the following service reviews:

- Prior authorization review
- Continued stay reviews

- Post-service reviews

Decisions affecting the coverage or payment for services are made in a fair, consistent and timely manner. All UM decisions are based on appropriateness of care, service and the benefit of coverage. UM decision-makers incorporate nationally recognized standards of care and practice from sources such as:

- American College of Cardiology
- American College of Obstetricians and Gynecologists
- American Academy of Pediatrics
- America Academy of Orthopedic Surgeons
- Cumulative professional expertise and experience

Once a case is reviewed, decisions and notification time frames will be given for:

- Approval of services
- Modification of services
- Deferral of services
- Denial of services

Note: HealthKeepers, Inc. does not reward practitioners and other individuals conducting utilization reviews for issuing denials of coverage or care. There are no financial incentives for UM decision-makers that encourage decisions resulting in under-utilization.

Clinical Utilization Management Guidelines

Clinical UM Guidelines are available on the website at **https://providers.anthem.com/va** > **Medical** > **Other Resources**.

If a provider disagrees with a UM decision and wants to discuss with the physician reviewer, providers can call Medical Management at **833-621-2129**. Choose option 2 for provider, then option 1 for a peer-to-peer request. Providers should be prepared to provide their availability and contact information, so a time can be set for the medical director to contact them.

Self-Referrals

Members may self-refer to the services listed below without a referral from their provider or prior authorization from HealthKeepers, Inc. Providers should direct members to in network providers for self-referral services; however, with the exception of behavioral health services, members may also receive self-referral services from DMAS-qualified providers. Self-referral services include, but are not limited to:

- Chiropractic services (for FAMIS members only)
- Diabetes self-management
- Emergency services

- Family-planning services
- Immunizations
- Outpatient behavioral health services (in-network only, if not provided by a psychiatrist)
- Psychiatric services
- Podiatric services
- Routine vision services

Second Opinions

A second opinion must be given by an appropriately qualified healthcare professional of the same specialty. HealthKeepers, Inc. will provide for a second opinion from a qualified healthcare professional within the network or arrange for the member to obtain one outside of the network, at no cost to the member.

Second opinions regarding medical necessities are offered at no cost to members.

Services Requiring Prior authorization

Authorization requirements are the responsibility of the provider and should be validated prior to service. Prior authorization requests should be made, at a minimum, three days before the scheduled/elective procedure/request. Failure to obtain prior authorization for an elective procedure/request may result in a denial for lack of prior authorization. To determine whether prior authorization is needed, use the Prior authorization Lookup Tool at **https://providers.anthem.com/va** > Prior authorization > Prior authorization Lookup Tool.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT was defined under the Omnibus Budget Reconciliation Act to provide periodic screenings, vision, dental and hearing services to individuals under 21 years of age. Medically necessary services are provided when the service is needed to correct or ameliorate a medical condition. Coverage may be available for services that are not usually covered for the rest of the Medicaid population. The EPSDT program does **not** require the provision of services that are specifically excluded under the member's benefit.

Services that **may** qualify for EPSDT include, but are not limited to, extended behavioral health benefits and private-duty nursing.

EPSDT does not apply to FAMIS members.

Additional Services

Behavioral Health

For information about behavioral health services, please see the **Behavioral Health Services** chapter.

Vision Care

HealthKeepers, Inc. contracts with EyeMed Vision Care for routine vision care. For questions, contact EyeMed Vision Care at **800-776-8364**.

Chiropractic Services

HealthKeepers, Inc. contracts with American Specialty Health (ASH) providers for chiropractic services. For prior authorization of all chiropractic services, contact ASH at **800-848-3555** or **https://www.ashcompanies.com**. See **Covered Services** for more information about eligibility. Note: This benefit is primarily for FAMIS members only.

Radiology/Therapy Services

If the authorization request is for radiology services or physical therapy, occupational therapy, and speech therapy being offered by Carelon Medical Benefits Management, the provider will need to submit a request using their provider portal at **www.providerportal.com** or call **855-574-6480.** Carelon Medical Benefits Management does not accept fax requests for initial prior authorization requests. Requests for PT/OT/ST in the home are handled by HealthKeepers, Inc.

Notifications of Changes

HealthKeepers, Inc. puts forth best efforts to notify providers of changes to authorization procedures via provider bulletins and newsletters. Provider bulletins are distributed to all network providers and then posted online at **https://providers.anthem.com/va > Communications**. Provider newsletters are also found on this page.

Prior authorization Form

The ***Prior authorization Request* form** is located at **https://providers.anthem.com/va**.

To get the fastest response on an authorization request, submit the request using the website.

To fax an authorization request:

- Fill out the form online, then print and fax it – this ensures legibility.
- Fill out the form completely – unanswered questions typically result in delays.
- Access the form online when one is needed, rather than pre-printing and storing it. HealthKeepers, Inc. revises the forms periodically, and outdated forms can delay a request.

Authorization Process

When authorization is required, call or fax HealthKeepers, Inc. with questions, including requests for:

- Routine, nonurgent care reviews
- Urgent or expedited pre-service reviews
- Urgent concurrent or continued stay reviews
- Nonurgent concurrent or continued stay reviews

Faxes are accepted during and after regular business hours. Faxes received after-hours will be processed the next business day.

An urgent request is any request for coverage of medical care or treatment in which the length of time required to make nonurgent care determinations could result in one of the following:

- Seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, based on a prudent layperson's judgment
- In the opinion of a practitioner with knowledge of the member's medical condition, subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request

Requesting Authorization

To request a pre-service review or report a medical admission, use the Availity Essentials Authorization and Referral application. You can also call Anthem HealthKeepers Plus Provider Services at **800-901-0020**. You may also fax the completed authorization form to **800-964-3627** with the following information:

- Member name and ID number
- Diagnosis with the ICD-10 code
- Procedure with the CPT code
- Date of injury or hospital admission and third-party liability information (if applicable)
- Facility name (if applicable)
- PCP (if known)
- Specialist or attending physician name
- Clinical justification for the request

The preferred method to submit a non-LTSS-related authorization request is via the website. Additional information to provide the clinical reviewer includes, but is not limited to:

- Office and hospital records
- History of the presenting problem
- Clinical exam
- Treatment plans and progress notes

- Diagnostic testing results
- Information on consultations with the treating practitioner
- Evaluations from other healthcare practitioners and providers
- Photographs
- Operative and pathological reports
- Rehabilitative evaluations
- Printed copy of criteria related to the request
- Information regarding the local delivery system
- Patient characteristics and information
- Information from responsible family members

Additional fax numbers:
- Expedited LTSS fax queue: **888-235-8390**
- Standard LTSS fax queue: **844-864-7853**

All providers — including physicians, hospitals, and ancillary providers — are required to provide information to the UM department within the specified time frames. Information that is not submitted timely may result in a denial for lack of information.

Authorization is not a guarantee of payment. Payment is based on eligibility at the time of service, and eligibility data is updated several times a month. It is possible that on initial and concurrent review the member shows as eligible, but later data feeds update the status to ineligible.

Requests with Insufficient Clinical Information
When the UM team receives requests with insufficient clinical information, HealthKeepers, Inc. will contact the provider with a request for the information reasonably needed to determine medical necessity.

HealthKeepers, Inc. will make at least one attempt to contact the requesting provider to obtain this additional information.

If additional clinical information is not received, a decision is made based upon the information available. If adequate clinical information is not received within 72 hours, the case will be referred to the medical director for review based on the information that was provided. Cases are either approved or denied coverage based on medical necessity and/or benefits. Members and providers will be notified of the determination by phone call and letter.

Timeliness of Utilization Management Decisions

Anthem HealthKeepers Plus Members (Cardinal Care and FAMIS)

Classification	Type	Timeliness	Extension
Physical/Non-Behavioral Health			
Urgent	Concurrent	72 hours	14 calendar days
	Preservice	72 hours	14 calendar days
Non-urgent	Preservice	7 calendar days	14 calendar days
Post Service	N/A	30 calendar days	14 calendar days
Behavioral Health including Mental Health and ARTS Services			
Urgent	Concurrent	72 hours	14 calendar days
	Preservice	72 hours	14 calendar days
Non-urgent	Preservice	7 calendar days	14 calendar days
Post Service	N/A	30 calendar days	14 calendar days

Service Authorizations

Continuity of Care for Cardinal Care Managed Care Members

HealthKeepers, Inc. will honor all previously approved authorizations made by DMAS or the member's previous managed care organization (MCO) for the duration of the service authorization or the first 30 calendar days the member is enrolled in Cardinal Care, whichever comes first. If the service authorization ends prior to when the initial HRA is completed, the continuity of care period continues until the HRA is completed and a new person-centered individual care plan has been implemented.

For more information about the HealthKeepers, Inc. continuity of care procedures, see the **Access Standards and Access to Care** chapter.

Emergency Services

Emergency Medical Conditions and Services

HealthKeepers, Inc. does not require prior authorization for treatment of emergency medical conditions and will cover emergency and post-stabilization services. HealthKeepers, Inc. will not retroactively deny a claim for an emergency screening examination because the condition was in fact a nonemergency.

An emergency medical condition involves acute symptoms of sufficient severity (including severe pain) that a prudent layperson could reasonably expect the absence of immediate medical attention to result in:

- Placing the member's health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

HealthKeepers, Inc. will not refuse to cover emergency services if the emergency room provider, hospital, or fiscal agent didn't notify the member's PCP or HealthKeepers, Inc. of the member's screening and treatment within 10 calendar days. In addition, members do not pay for the subsequent screening and treatment needed to diagnose the specific condition or stabilize them.

In accordance with Section 1867 of the Social Security Act, hospitals offering emergency services are required to perform a medical screening examination on all people who come to the hospital seeking emergency care, regardless of their insurance status or other personal characteristics. If an emergency medical condition is found to exist, the hospital must provide whatever treatment is necessary to stabilize that condition. A hospital may not transfer a patient in an unstable emergency condition to another facility, unless the medical benefits of the transfer outweigh the risks and the transfer conforms to all applicable requirements.

If the hospital and HealthKeepers, Inc. disagree on whether the member is stable enough for discharge or transfer, or whether the medical benefits of an unstable transfer outweigh the risks, the judgment of the attending physician(s) prevails; HealthKeepers, Inc. must abide by this decision.

In the event of an emergency, members can access emergency services 24/7. The facility does not have to be in-network. In the event that the emergency room visit results in the member's admission to the hospital, providers must contact HealthKeepers, Inc. within 24 hours or no later than the first business day after admission once the member is stable. Lack of timely notification could result in a denial for late notification.

Reimbursements and Payments

HealthKeepers, Inc. will cover post-stabilization care services that are:

- Preapproved by a participating provider or HealthKeepers, Inc.
- Not preapproved by a participating provider or HealthKeepers, Inc., but administered to maintain the member's stabilized condition within one hour of submitting a prior authorization request for further post-stabilization care services.
- Not preapproved by a participating provider or HealthKeepers, Inc., but administered to maintain, improve or resolve the member's stabilized condition if either:
  - HealthKeepers, Inc. does not respond to a prior authorization request within one hour.

- HealthKeepers, Inc. cannot be contacted.
- HealthKeepers, Inc. and the treating physician cannot reach an agreement about the member's care and a plan physician is not available for consultation. In this situation, HealthKeepers, Inc. must give the treating physician the opportunity to consult with a plan physician, and the treating physician may continue with care of the member until a plan physician is reached or until one of the criteria listed below is met.

HealthKeepers, Inc.'s financial responsibility for unapproved post-stabilization care services ends when:

- A plan physician with privileges at the treating hospital assumes responsibility for the member's care.
- A plan physician assumes responsibility for the member's care through transfer.
- HealthKeepers, Inc. and the treating physician reach an agreement concerning the member's care.
- The member is discharged.

If the examining physician determines an emergency medical condition does not exist, HealthKeepers, Inc. will pay for all services involved in the screening examination; however, the presenting symptoms (including severe pain) must have been of sufficient severity to have warranted emergency attention. If a member believes that a claim for emergency services has been inappropriately denied, they may utilize the HealthKeepers, Inc. appeal process.

Emergency Stabilization and Post-Stabilization

The emergency department's treating physician determines the services needed to stabilize the member's emergency medical condition. After the member is stabilized, the emergency department's physician must contact the member's PCP for authorization of further services. The member's PCP is noted on the back of the ID card. If the PCP does not respond within one hour, the needed services will be considered authorized.

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

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

If post-stabilization care is required: retrospective authorization requests are accepted for seven days following the actual date of service. Emergent admission notifications are entered 24/7 by nonclinical and clinical teams in the National Call Center. The concurrent review team would determine medical necessity of the emergent admission.

Referrals to Specialists

The UM team is available to assist providers in identifying a network specialist and/or arranging for specialist care. Keep the following in mind when referring members:

- UM authorization is not required if referring a member to an in-network specialist for consultation or a nonsurgical course of treatment.
- UM authorization is required when referring to an out-of-network specialist.
- UM authorization is required for an out-of-network referral when an in-network specialist is not available in the geographical area.
- Providers must obtain a prior authorization approval number before referring members to an out-of-network provider. For out-of-network providers, HealthKeepers, Inc. requires this prior authorization for the initial consultation and each subsequent service provided.

The provider is responsible for documenting referrals in the member's chart and requesting that the specialist provide diagnosis and treatment updates.

Out-Of-Network Exceptions

There are several geographical exceptions to using in-network providers:

- Anthem HealthKeepers Plus members are allowed to use the services of out-of-network providers if no provider is available in the member's service area.
- HealthKeepers, Inc. makes covered services provided by federally qualified health clinics (FQHCs) and rural health clinics (RHCs) available to members out of network if those clinics are not available in the member's service area and within the Anthem HealthKeepers Plus network if those clinics are not available in the member's service area and within the Anthem HealthKeepers Plus network.
- If an in-network provider is not available within the time and distance standards of the member's residence noted in Chapter 15, HealthKeepers, Inc. may authorize out-of-network services and cover the services for as long as those services are unavailable in-network.

Members with special needs who have been determined to need a course of treatment or regular care monitoring can directly access an out-of-network specialist after prior authorization approval. Treatment provided by the specialist must be appropriate for the member's condition.

Hospital Inpatient Admissions

Hospitals must notify the UM department of inpatient medical or behavioral health admissions within 24 hours, or no later than the first business day after admission. The UM department then notifies the provider that clinical information supporting the need for admission must be sent within one business day. Untimely notification could result in a denial for late notification. Providers should send the clinical information from the

initial two days of admission. Evidence based criteria are used to determine medical necessity and the appropriate level of care.

Notification for all post-stabilization admissions, including transfers, should occur within one business day of admission. The following clinical scenarios are deemed as an emergency; therefore, notification should occur within 10 calendar days from presentation for emergency services:

- Admission to a neonatal intensive care unit (NICU)
- Admission to an intensive care unit (ICU)
- Direct admission to an operating room (OR)/recovery room
- Direct admission to a telemetry floor
- Direct admission from the emergency room
- Involuntary behavioral health admission

Prior authorization is required for the following:

- Nonemergent inpatient transfers between acute facilities for a lower level of care
- Elective inpatient admissions
- Rehabilitation facility admissions
- Long-term acute care hospital admissions
- Skilled nursing facility admissions (covered for FAMIS members only)

Payment is based on eligibility at the time of service, and eligibility data is updated several times a month. It is possible that on initial and concurrent review the member shows as eligible, but later data feeds update the status to ineligible.

DMAS Specifications for Readmission Payment Reduction Policy Effective July 1, 2020

The 2020 Appropriation Act (Chapter 1289) includes the following change in hospital readmission reimbursement.

Item 313.BBBBB — *The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance Services under Title XIX to modify the definition of readmissions to include cases when patients are readmitted to a hospital for the same or a similar diagnosis within 30 days of discharge, excluding planned readmissions, obstetrical readmissions, admissions to critical access hospitals, or in any case where the patient was originally discharged against medical advice. If the patient is readmitted to the same hospital for a potential preventable readmission then the payment for such cases shall be paid at 50 percent of the normal rate, except that a readmission within five days of discharge shall be considered a continuation of the same stay and shall not be treated as a new case. Similar diagnoses shall be defined as ICD diagnosis codes possessing the same first three digits. The department shall have the authority to implement this reimbursement change effective July 1, 2020, and prior to the*

completion of any regulatory process undertaken in order to effect such change. The department shall report quarterly on the number of hospital readmissions, the cost, and the primary diagnosis of such readmissions to the Joint Subcommittee for Health and Human Resources Oversight.

This reimbursement reduction is included as an adjustment to the FY21 capitation rates.

The current and new policies apply only to DRG claims from acute care hospitals (does not apply to psych, rehab or transplant claims).

If the patient is discharged from the facility and readmitted within five days from the date of discharge with the same or similar principal diagnosis (first three alpha or numeric characters), the two claims are combined and treated as one claim for payment purposes. This policy remains in effect with no changes.

If a patient is discharged from a facility and readmitted to the same facility within 6 to 30 days from date of discharge with same or similar principal diagnosis (first three alpha or numeric characters), payment will be reduced by 50%. Readmission within 30 days of the most recent admission qualifies for the readmission reduction even if the most recent admission is also a qualifying readmission.

Exclusions for the 6 to 30-day readmissions (claims that meet one of the exclusions are paid in full):

Planned Readmissions:
Exclude readmissions with the following discharge status codes on the first admission:

- 81 = Discharged to Home or Self Care with a Planned Acute Care Hospital Inpatient Readmission
- 82 = Discharge/Transfer to a Short Term General Hospital for Inpatient Care with a Planned Acute Care Hospital Inpatient Readmission
- 83 = Discharged/Transferred to a Skilled Nursing Facility (SNF) with Medicare Certification with a Planned Acute Care Hospital Inpatient Readmission
- 84 = Discharged/Transferred to a Facility that Provides Custodial or Supportive Care with a Planned Acute Care Hospital Inpatient Readmission
- 85 = Discharged/transferred to a Designated Cancer Center or Children's Hospital with a Planned Acute Care Hospital Inpatient Readmission
- 86 = Discharged/ Transferred to Home Under Care of Organized Home Health Service in Anticipation of Covered Skilled Care with a Planned Acute Care Hospital Inpatient Readmission
- 87 = Discharged/ Transferred to Court/Law Enforcement with a Planned Acute Care Hospital Inpatient Readmission

- 88 = Discharged/Transferred to a Federal Health Care Facility with a Planned Acute Care Hospital Inpatient Readmission
- 89 = Discharged/Transferred to a Hospital-based Medicare Approved Swing Bed with a Planned Acute Care Hospital Inpatient Readmission
- 90 = Discharged/Transferred to an Inpatient Rehabilitation Facility (IRF) including Rehabilitation Distinct Part Units of a Hospital with a Planned Acute Care Hospital Inpatient Readmission
- 91 = Discharged/transferred to a Medicare Certified Long Term Care Hospital with a Planned Acute Care Hospital Inpatient Readmission
- 92 = Discharged/Transferred to a Nursing Facility Certified Under Medicaid but not Certified Under Medicare with a Planned Acute Care Hospital Inpatient Readmission
- 93 = Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital with a Planned Acute Care Hospital Inpatient Readmission
- 94 = Discharges/Transferred to a Critical Access Hospital (CAH) with a Planned Acute Care Hospital Inpatient Readmission
- 95 = Discharged/Transferred to Another Type of Health Care Institution not Defined Elsewhere in this Code List with a Planned Acute Care Hospital Inpatient Readmission

Patient Originally Discharged Against Medical Advice:
Exclude readmissions with discharge status code on the first admission

- 07 = Left Against Medical Advice

Obstetrical Readmissions:
Exclude readmissions if the principal diagnosis code on the readmission is:

- Ectopic and Molar Pregnancy (O01.9 – O00.81)
- Other Pregnancy with Abortion Outcome (O03.9- O03.30)
- Complications Mainly Related to Pregnancy (O99.891-O75.82),
- Normal Delivery and Other Indications for Care in Pregnancy, Labor and Delivery, Complications Occurring Mainly in the Course of Labor and Delivery (O66.9-O75.9)
- Complications of the Puerperium (O86.89-O94), Other Maternal and Fetal Complications (O36.8910-O35.7)

Readmissions to Critical Access Hospitals:
Exclude readmissions if the provider equals Critical Access Hospital. DMAS has provided the current list of Critical Access Hospitals and their Medicaid provider number and NPI in the DMAS' provider enrollment file. MCOs should verify enrollment in their claims processing systems.

Provider Number	Provider Name	NPI
4900855	Carilion Giles Community Hospital	1033102942
4900472	Page Memorial Hospital, Inc.	1326040684
4901231	Rappahannock Gen Hosp	1922004530
4900065	Shenandoah Mem Hosp	1033166442
4900316	Stonewall Jackson Hosp	1518950484
10038146	Dickenson Community Hospital	1285685727
4900995	Bath County Comm Hosp	1417989278

Reducing Qualifying Readmissions by 50%

- DMAS pays all DRG claims initially and looks back during a "monthly case building" process that includes claim history to identify claims that should be modified for payment for multiple reasons. DMAS will identify claims subject to the readmission reduction during the monthly case building and will reprice the claim, including capital, but before deductions for private insurance payments. The readmission is then automatically "adjusted" on the next remittance cycle.
- MCOs may process claims similar to DMAS or identify the claims subject to the readmission reduction using claims history. DMAS has asked 3M to modify the Virginia DRG Software to accept a readmission flag that will price the claim with a 50% reduction. MCOs can choose to use this feature.
- HealthKeepers, Inc. will pend all Clean Claims for review and manually price claims. However, a post-payment review will be done, as well, to identify same or similar diagnoses not originally identified by the manual claims process.

NEW 6 to 30-day Readmission Examples:

Example: Member admitted July 1, 2020, and discharged July 4, 2020, (**First** admission); admitted on July 15, 2020, and discharged on August 5, 2020, (**Second** admission). The second admission is subject to the 50% reduction unless it meets one of the exceptions.

Readmission 6 to 30-day with Three Admissions:

Example: Member admitted June 22, 2020, and discharged July 2, 2020, (**First** admission); admitted on July 10, 2020, and discharged on July 20, 2020, (**Second** admission); admitted August 3, 2020, and discharged August 25, 2020, (**Third** admission). The second and third admissions are subject to the 50% reduction unless they meet one of the exceptions.

Denial of Service

Administrative Denials

An administrative denial is a denial for payment of a requested service or confinement for reasons unrelated to medical necessity.

Administrative denials do not require review by a medical director or appropriate practitioner. Examples of administrative denials include:

- Late notification by a practitioner of an admission.*
- Failure of a practitioner to obtain prior authorization for a service that requires prior authorization.
- The member is ineligible on the date of service.

*** For urgent/emergent services:** If the emergency room provider, hospital or fiscal agent did not notify the member's PCP or HealthKeepers, Inc. of the member's screening/treatment within 10 calendar days of presentation for emergency services, HealthKeepers, Inc. will **not** deny for late or non-notification of admission.

If the admission was not urgent/emergent, services will be denied for late notification.

Denials for Lack of Medical Necessity

Only a medical or behavioral health physician reviewer who possesses an active professional license or certification can deny services for lack of medical necessity, including but not limited to the denial of:

- Procedures
- Hospitalization
- Equipment
- Private-duty nursing
- Home health services

When a request is determined to be not medically necessary, the requesting provider will be notified of the decision as well as the process for re-review, peer to peer review and appeals.

Peer-to-Peer

A peer-to-peer (P2P) is the process of giving a member's treating or ordering practitioner the opportunity to discuss a medical necessity denial decision with an appropriate health plan medical director (or appropriate practitioner). This can occur anytime during the review process, and no later than three days after the denial letter is issued. Unless otherwise stipulated as a health plan exception, a discussion between a health plan medical director (or appropriate practitioner) and an advisor who is not involved directly in the care of a member does not meet the definition of a P2P. Note: All P2Ps have to be conducted with the member's attending physician.

For medical peer-to-peer requests, call **833-621-2129**. Select 1 for provider, then select 2 for a peer-to-peer request.

Medical Necessity — Re-reviews

Re-reviews are considered an informal process afforded to the provider on behalf of the member and occur if the requesting practitioner contacts the health plan within three business days of issuance of the initial determination letter and no other re-reviews or P2Ps have occurred. If the request is received by the health plan after three business days of the issuance of the initial determination letter, the practitioner will be required to follow the formal appeals process outlined below.

In order to initiate the re-review process, the requesting practitioner contacts the health plan to request a re-review.

All urgent preservice and all concurrent re-reviews shall occur within three business day of receipt of the request. All nonurgent preservice and all post-service re-reviews shall occur within three business days of receipt of the request. All re-reviews are conducted by the member's attending practitioner, and the health plan medical director makes the initial determination (or appropriate practitioner under the direction of the health plan medical director if the original health plan medical director is not available). The health plan medical director completes the re-review with the attending practitioner.

In order to avoid the need for a re-review, providers are strongly encouraged to submit all applicable information that the health plan medical director would need when requesting the initial review.

For re-reviews, fax additional information for outpatient services to **866-920-4096** and inpatient admissions to **866-920-4095**.For Behavioral Health re-review, submit the information via Availity Essentials or by fax **844-445-6646** for all ARTS, Inpatient Psychiatric Hospitalization, Mental Health Intensive Outpatient Program, Mental Health Partial Hospitalization Program, Community Stabilization, Mobile Crisis Response, 23-hour Crisis Stabilization, and Residential Crisis Stabilization authorization requests. For all other Behavioral Health outpatient service authorization requests, please use the standard fax line **844-445-6642**.

Providers can contact the physician reviewers to discuss any UM decision by calling Medical Management at **833-621-2129**. Select 1 for provider then select 2 for a peer-to-peer request. For more information about UM decisions and how to appeal them, see the **Grievances and Appeals** chapter.

Post-Service/Retrospective Review

Post-service review determines the medical necessity and/or level of care for services that were provided without obtaining required authorization. For inpatient admissions where no notification was received at the time of admission and no claims have been submitted, HealthKeepers, Inc. will review for medical necessity in accordance with timely filing practices. Outpatient services that occurred within seven days from the date of notification will be reviewed for medical necessity.

Any services that were already billed and denied for no prior authorization must follow the claims appeal process.

Hospital Emergency Department Assistance

Hospitals may elect to refer patients with nonurgent/nonemergent conditions to alternative settings for treatment if the member does not require inpatient admission. Hospitals and members may contact the Anthem HealthKeepers Plus care coordination team at **800-901-0020, option 1** to receive assistance in scheduling an appointment at a nonemergency facility.

CHAPTER 10: HEALTH SERVICES PROGRAMS

Overview

Health services programs are designed to help improve members' overall health and well-being by informing, educating and encouraging self-care in the early detection and treatment of existing conditions and chronic disease.

These targeted programs supplement providers' treatment plans and are divided into three categories:

- Preventive care
- Health management
- Health education

Preventive Care

Health Screenings and Immunizations

One of the best ways to promote and protect good health is to prevent illness. Anthem HealthKeepers Plus members are covered for routine health screenings and immunizations. Additionally, Anthem HealthKeepers Plus health services programs provide members with guidelines, reminders and encouragement to stay well. Members may receive:

- Information about health issues
- Flu shot reminders
- Health screening reminders, such as breast and cervical cancer screenings

Initial Health Assessments

Initial health assessments (IHAs) give providers the baseline they need to assess and manage a member’s physical condition. After the IHA is completed, providers can give members educational support that allows them to become more actively engaged in their own treatment and preventive healthcare.

New members’ IHAs should be performed by the PCP within 60 days of enrollment. The IHA consists of the following categories of patient information:

- Patient history
- Physical examination
- Developmental assessment
- Vision and hearing screening
- Health education
- Screenings and immunizations
- Behavior assessment

An IHA is **not** necessary under the following conditions:

- If the new member is one of the PCP's existing patients (but new to the Anthem HealthKeepers Plus plan) with an established medical record showing baseline health status. This record must include sufficient information for the PCP to understand the member's health history and provide treatment recommendations as needed.
- If the new member is not an existing patient, transferred medical records can also meet the requirements for an IHA, if a completed health history is included.

Early and Periodic Screening, Diagnostic and Treatment Services Program
In Virginia, the Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) program is a comprehensive and preventive child-health program for Anthem HealthKeepers Plus members younger than 21 years of age. As an integral part of this program, PCPs offer age-appropriate preventive care screening and testing during each well-child visit and during an acute illness episode, if appropriate.

Screening requirements: PCPs should offer health education, counseling and guidance to the member, parent or guardian. An evaluation of age-appropriate risk factors should be performed at each visit. In addition, PCPs should perform the following:

- A comprehensive health and developmental history, including both physical and behavioral health development
- A comprehensive unclothed physical exam, which includes pelvic exams and Pap tests for sexually active females
- Appropriate immunizations according to age and health history
- Documented and current immunizations
- Height, weight and body mass index (BMI) assessment
- Laboratory tests, including screenings for blood lead levels
- Nutritional assessment
- Tuberculosis screening
- Dental assessment
- Sensory screening (vision and hearing)
- Health education
- Vision and hearing screening (under Cardinal Care)

Responsibilities: Information on Anthem HealthKeepers Plus preventive care programs is provided in the member handbook, which is sent to new members at the time of enrollment. Member newsletters and the member website include special features about the health services programs, including ongoing reminders on the importance of an initial health assessment, well-child visits, immunizations and regular checkups.

In addition, HealthKeepers, Inc. uses live and/or automated calls to reach out to members as outlined below:

- Health needs screening (HNS) reminder calls to all newly enrolled members within 90 days of enrollment
- Immunization reminder calls to the parents/guardians of members
- Annual preventive care/well visit reminder calls to members

Childhood Lead Exposure Testing/Free Blood Test Kits

CMS requires all children enrolled in Medicaid are tested for lead exposure at 1 and 2 years of age. Children from 3 to 6 years of age who have not been tested also need screening, regardless of their risk factors.

Note: Completion of a lead risk assessment questionnaire does not fulfill this screening requirement; a blood draw is also required.

In accordance with the Virginia "Reportable Disease" regulations at 12 VAC 5-90-215, HealthKeepers Inc. requires that all "detectable" blood lead levels for its members be reported to the local Health Department within three (3) days. Lead reportable levels, consistent with 12 VAC 5-90-10, means any detectable blood lead level in children fifteen (15) years of age and younger and levels greater than or equal to five (5) µg/dL in a person older than fifteen (15) years of age. Providers must report children's blood lead levels that are greater than or equal to five (5) µg/dL using the EP-1 form located on the Virginia Department of Health (VDH) website.
HealthKeepers, Inc. has contracted with LabCorp, who manages the MEDTOX* Laboratories program, to provide free, easy-to-use lead exposure screening kits to providers. These kits contain:

- A blood sample card
- Lancets (upon request)
- A plastic, sealable storage bag
- Pediatric lead/hemoglobin requisition form
- Prepaid envelope (large envelopes are available upon request)

To order your free MEDTOX lead exposure blood testing kits, please call MEDTOX to arrange for an initial order and to set up an account. LabCorp can be reached at **800-832-3244**.

Note: A blood lead test result equal to or greater than five micrograms per one deciliter obtained by capillary specimen (finger stick) must be confirmed using a venous blood sample.

Member Incentives: Clinic Day Program
HealthKeepers, Inc. launched a quality initiative designed to improve compliance rates for various health services and HEDIS measures for members. The initiative engages members and providers to improve access to care and patient compliance. In partnership with network providers, HealthKeepers, Inc. hosts a series of clinic days to treat members who have not completed specific recommended health services.

A clinic day is when a provider agrees to hold open appointments for particular health services for the course of one or more days. These events offer a fun way to encourage Anthem HealthKeepers Plus patients to obtain the health services they need, while improving HEDIS scores and decreasing no-shows. They also allow for open communication between the doctors, patients and HealthKeepers, Inc.

Clinic days are valuable because they:
- Improve members' quality of life, specifically in relation to certain healthcare needs
- Bolster member and provider satisfaction
- Increase HEDIS scores

HealthKeepers, Inc. shows support and appreciation to each provider by distributing member invitations and appointment reminders, providing a display table for giveaways and health information, and providing lunch for providers and office staff.

Educational activities include:
- Making sure members understand their benefits
- Helping members obtain resources needed (for example, social services addresses and phone numbers)
- Providing contact information for any issues that arise
- Offering health-education materials and giveaways

Only a subset of all members within a practice panel who have not completed specific recommended health services and HEDIS measures will be targeted for participation. Every effort is made to help prevent no-shows to ensure a successful clinic day. Prior to the event, Quality Management representatives work with members to identify solutions to any barriers that may cause a no-show to occur. Transportation arrangements are made for qualifying Anthem HealthKeepers Plus members. In addition, a gift card incentive will be provided to members for their participation in the clinic day for an approved service.

Health Management

Care Management/Care Coordination Programs

Care Management/Care Coordination
Our Care Managers/Care Coordinators work directly with your patients to assess their needs in a holistic approach taking into consideration their physical and mental health, developmental, psychosocial, academic and financial needs. Our interdisciplinary teams of nurses, social workers and doctors work together to identify gaps in care and work to find solutions that meet your patients' needs.

Our care managers complete a thorough assessment with medical history and work with your patient to create a care plan that is member centric and agreeable to the patient. Care managers work closely with the patients on their goals to help maintain or improve their overall health status. We provide your patients with additional resources available in their local communities, educate them on their benefits and assist them in coordinating their care as needed.
Our care management programs are all voluntary and available to all members.

New Baby, New Life℠
New Baby, New Life is a is a proactive care management program for all perinatal members and their newborns. We use several resources to identify pregnancies as early as possible. Sources of identification include state enrollment files, claims data, and hospital census reports as well as provider and member self-referrals. Once pregnant members are identified, we act quickly to assess obstetrical risk and ensure appropriate levels of care management services to mitigate risk.
Experienced care managers/care coordinators work with members and providers to establish a care plan for the highest risk pregnant members. They may also collaborate with community partners to facilitate connecting members to local and national agencies who can assist with services and support.

When it comes to pregnancy, we are committed to healthy outcomes for our members and their babies. That is why we encourage all of our pregnant and postpartum members to take part in our New Baby, New Life℠ program, a comprehensive 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 encourage members to keep up with checkups
- Proactive care coordination and complex care management support for parents of infants that are admitted to the neonatal intensive care unit (NICU)

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

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

We encourage notification of pregnancy at the first prenatal visit and notification of delivery following birth. You may choose to complete the notification of pregnancy and delivery in Availity Essentials or fax the forms to HealthKeepers, Inc. at **800-964-3627**.

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

- Perform an Eligibility and Benefits (E&B) request on the desired member.
- Choose one of the following benefit service types: maternity, obstetrical, gynecological, or obstetrical/gynecological.
- If the appropriate conditions apply for payer, user, member and service type, the maternity question screen will display. Conditions include:
  - The member is female
  - The member is 45 years of age or under
  - The member is 15 years of age or over
- If the member is not pregnant, select no and submit to continue to the E&B response screen.
- If the member is pregnant, select yes and submit. You will be prompted to enter additional dates if known:
  - The Estimated Due Date
  - The first prenatal appointment date
- When YES is selected, the maternity data entered is saved for this member.

- After submitting your answer, the E&B response screen will display.

We encourage healthcare providers to share information about this program and the digital perinatal app with members. Members may access information about the products that are available by visiting the HealthKeepers, Inc. member website.

For more information about the New Baby, New Life program or the digital app, reach out to Provider Services at **800-901-0020**, or refer to our website at **https://providers.anthem.com/virginia-provider/patient-care/maternal-child-services**.

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

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

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

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

For more information about our NICU Care Management program, reach out to Provider Services at **800-901-0020**, or refer to our website at **https://providers.anthem.com/virginia-provider/patient-care/maternal-child-services**.

Breastfeeding Support Tools and Services
The American Academy of Pediatrics, the American College of Obstetrics and Gynecology, and the American Public Health Association recognize breastfeeding as

the preferred method of infant feeding. Providers should encourage breastfeeding for all pregnant women, unless it is not medically appropriate.

To support this goal, HealthKeepers, Inc. asks providers to:

- Assess all pregnant women for health risks that are contraindications to breastfeeding, such as HIV/AIDS and active tuberculosis.
- Provide breastfeeding counseling and support to all breastfeeding postpartum women immediately after delivery.
- Assess postpartum women to determine the need for lactation durable medical equipment such as breast pumps and breast pump kits.
- Document all referrals and treatments related to breastfeeding in the member's medical record; pediatricians should document frequency and duration of breastfeeding in the baby's medical record.
- Refer pregnant and postpartum women to the 24/7 NurseLine for information, support and referrals.
- Refer pregnant women to community resources that support breastfeeding, such as the Women, Infants and Children (WIC) program.
- Support continued breastfeeding during the postpartum visit.

Health Education

24/7 NurseLine

HealthKeepers, Inc. recognizes questions about healthcare prevention and management don't always come up during office hours. The 24/7 NurseLine, a 24/7 phone line staffed by registered nurses, provides a powerful provider support system and is an invaluable component of after-hours care. The 24/7 NurseLine allows members to closely monitor and manage their own health by giving them the ability to ask questions whenever they come up. Reach the 24/7 NurseLine at **800-901-0020** (**TTY 711**) for the Anthem HealthKeepers Plus plan.

Members can call 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 teenage members
- Information on more than 300 healthcare topics through the 24/7 NurseLine audio health library

Providers may use the 24/7 NurseLine as a resource for members to call for nonemergent questions and information. Members who contact the 24/7 NurseLine prior to visiting an emergency room will not be subject to copays.

Note: The 24/7 NurseLine has access to telephone interpreter services for callers who do not speak English. All calls are confidential.

Condition Care (formerly Disease Management)

Our Condition Care (CNDC) (formerly Disease Management) services are based on a system of coordinated care management interventions and communications designed to help physicians and other healthcare professionals manage members with chronic conditions. Condition Care services include a holistic, member-centric care management approach that allows case managers to focus on members' multiple needs. Condition Care programs include:

- Asthma
- Bipolar disorder
- Chronic obstructive pulmonary disorder (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Diabetes
- HIV/AIDS
- Hypertension
- Major depressive disorder — adult
- Major depressive disorder — child/adolescent
- Schizophrenia
- Substance use disorder

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

Program Features

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

Clinical Practice Guidelines are available by logging in to the provider website at **www.https://providers.anthem.com/va.** A copy of the guidelines can be printed from the website, or providers can call Anthem HealthKeepers Plus Provider Services at **800-901-0020** to receive a copy.

Who Is Eligible?
All members diagnosed with one or more of listed conditions are eligible for Condition Care services.

As a valued provider, HealthKeepers, Inc. welcomes referrals of patients who can benefit from additional education and care management support. Case managers will work collaboratively with providers to obtain 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. They are provided with continuous education on self-management concepts, including primary prevention, coaching related to healthy behaviors, and compliance/monitoring, as well as case/care management for high-risk members. Providers are given telephonic and/or written updates regarding patient status and progress.

Condition Care Provider Rights
Providers have the right to:

- Have information about HealthKeepers, Inc., including:
- Provided programs and services
- Our staff
- Our staff's qualifications
- Any contractual relationships
- Decline to participate in or work with HealthKeepers, Inc. programs and services for patients
- Be informed of how HealthKeepers, Inc. coordinates interventions with patients' treatment plans
- Know how to contact the person who manages and communicates with patients
- Be supported by HealthKeepers, Inc. when interacting with patients to make healthcare decisions
- Receive courteous and respectful treatment from HealthKeepers, Inc. staff
- Communicate complaints about CNDC as outlined in the HealthKeepers, Inc. Provider Complaint and Grievance Procedure

Hours of Operation
Case managers are licensed nurses. They are available
8:30 a.m. to 5:30 p.m. local time.

Confidential voicemail is available 24 hours a day, and the 24/7 NurseLine is available for members 24 hours a day, 7 days a week.

Contact Information
Providers can call a Condition Care team member at **888-830-4300 or email us at Condition-Care-Provider-Referral@anthem.com**. CNDC program content is located at **https://providers.anthem.com/virginia-provider/patient-care/condition-care**.

Health Management: Healthy Families
Healthy Families is a six-month program for children 7 to 17 years of age who are overweight, obese, or at risk of becoming overweight or obese. Healthy Families includes coaching using motivational interviewing, lifestyle education and written materials to support member-identified goals. Members can be referred to the program by calling **844-421-5661.**

Provider Responsibilities

These provider responsibilities help members maintain healthy lifestyles:

- Document all healthcare screenings, immunizations, procedures, health education and counseling in the member's medical record.
- Provide immunizations at all well-child visits as needed, according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) and the American Academy of Pediatrics (AAP).-child visits as needed, according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) and the American Academy of Pediatrics (AAP).
- Refer members to dentists, optometrist/ophthalmology or other specialists as needed, and document referrals in the member's medical record.
- Schedule preventive care appointments for all children in accordance with the AAP Periodicity Schedule.

CHAPTER 11: CLAIMS AND BILLING

Electronic Data Interchange (EDI)

HealthKeepers, Inc. uses Availity Essentials as its exclusive partner for managing all electronic data interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (835) allows for a faster, more efficient and cost-effective way for providers and employers to do business.

Advantages of Electronic Data Interchange (EDI)

- Process claims faster by submitting coordination of benefits electronically and fixing errors early with in-system notification and correction
- Reduce overhead and administrative costs by eliminating paper claim submissions

Use Availity Essentials for the following EDI transactions:

- Healthcare Claim: Professional (837P)
- Healthcare Claim: Institutional (837I)
- Healthcare Claim: Dental (837D)
- Healthcare Eligibility Benefit Inquiry and Response (270/271)
- Healthcare Services Prior Authorization (278)
- Healthcare Services Inpatient Admission and Discharge Notification (278N)
- Healthcare Claim Payment/Advice (835)
- Healthcare Claim Status Request and Response (276/277)
- Medical Attachments (275)

Ways you can use the Availity Essentials EDI Gateway

Availity Essentials' EDI submission options:

- EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software)
- Or use your existing clearinghouse or billing vendor (work with your vendor to ensure connection to the Availity Essentials EDI Gateway)

Electronic Data Interchange Trading Partner

Trading partners connects with Availity Essentials' EDI gateway to send and receive EDI transmissions. A Trading Partner can be a provider organization using software to submit direct transmissions, billing company or a clearinghouse vendor.

To become an EDI Trading Partner visit **htttps://Availity.com**.

Login if already an Availity Essentials user, choose My providers > Transaction Enrollment or choose Register if new to Availity Essentials.

Payer ID: **00423**

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

Electronic Remittance Advice (835)
The 835 eliminates the need for paper remittance reconciliation.

Use Availity Essentials to register and manage ERA account changes with these three easy steps:

1. Log in to Availity Essentials: **https://apps.availity.com/availity/web/public.elegant.login**
2. Select My Providers.
3. Select Enrollment Center and select Transaction Enrollment.

Note: If you use a clearinghouse or vendor, please work with them on ERA registration and receiving your ERAs.

Electronic Funds Transfer (EFT)
Electronic claims payment through electronic funds transfer (EFT) is a secure and fastest way to receive payment reducing administrative processes. EFT deposit is assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.

Visit **https://providers.anthem.com/virginia-provider/claims/electronic-data-interchange** for EFT registration instructions.

Web-based Claims Submissions

Providers can also submit claims through Availity Essentials by logging in at **https://Availity.com** and following the instructions to register.

Paper Claims Submission

Providers must submit clean claims on a properly completed CMS-1450 (UB04) or CMS-1500 (02-12) claim form:

- On the original red claim forms (not black and white or photocopied forms)
- Laser-printed or typed (not handwritten)
- In a large, dark font

Note: Providers may submit handwritten claims, but the entire claim must be handwritten.

CMS-1500 and CMS-1450 (UB04) forms are available on the CMS website at **www.cms.hhs.gov.**

Submit paper claims to:
Anthem HealthKeepers Plus — Claims
Claims
P.O. Box 61010
Virginia Beach, VA 23466

There are exceptions to the timely filing requirements. They include:

- **Cases of coordination of benefits/subrogation:** Time frames for filing a claim will begin on the date of the primary payer determination of the claim.
- **Cases where a member has retroactive eligibility:** Time frames for filing a claim will begin on the date HealthKeepers, Inc. receives notification from the enrollment broker of the member's eligibility/enrollment.

Claim forms must include the following information (HIPAA-compliant where applicable):

The CMS-1450 (UB04) and CMS-1500 claim forms should be completed according to CMS guidelines.

HealthKeepers, Inc. cannot accept, and will return, claims with alterations to billing information. Returned claims will include an explanation of the reason for the return.

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

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

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

Although the term ICD-10 is often used alone, there are actually two parts to ICD-10:

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

ICD-10-CM replaces the code sets ICD-9-CM, volumes one and two for diagnosis coding, and ICD-10-PCS replaces ICD-9-CM, volume three, for inpatient hospital procedure coding.

Claims Adjudication

HealthKeepers, Inc. is dedicated to providing timely adjudication of claims and process all claims according to generally accepted claims coding and payment guidelines, defined by the CPT-4 and ICD-10 manuals.

Providers must use HIPAA-compliant billing codes; when billing codes are updated, providers are required to use appropriate replacement codes for submitted claims. HealthKeepers, Inc. will reject claims submitted with noncompliant billing codes. HealthKeepers, Inc. reserves the right to use code-editing software to determine which services are considered part of, incidental to or inclusive of the primary procedure.

To ensure clean and complete claims, providers should use the Claims Transaction User Guide at **https://providers.anthem.com/va**.

Timely filing

Claims must be submitted within 12 months from the date of discharge for inpatient services, 12 months from the date of service for outpatient services, or as otherwise stated in the provider contract.

Documentation of Timely Claim Receipt

The following information will be considered proof that a claim was received timely. If the claim is submitted:

- **By United States mail:** first-class or overnight delivery service return receipt as well as a copy of the claim log that identifies each claim included in the submission
- **Electronically:** the clearinghouse-assigned receipt date from the reconciliation reports
- **By fax**: proof of facsimile transmission
- **By hand delivery:** a copy of the signed receipt acknowledging hand delivery as well as a copy of the claim log that identifies each claim included in the delivery

The claim log maintained by providers must include the following information:

- Name of claimant
- Address of claimant
- Telephone number of claimant
- Claimant’s federal tax identification number
- Name of addressee
- Name of carrier
- Designated address

- Date of mailing or hand delivery
- Subscriber name
- Subscriber ID number
- Patient name
- Date(s) of service/occurrence
- Total charge
- Delivery method

Good Cause

If the claim or claim dispute includes an explanation for the delay, or other evidence that establishes the reason, HealthKeepers, Inc. will determine good cause based primarily on that statement or evidence. HealthKeepers, Inc. will contact the provider for clarification or additional information necessary to make a good-cause determination.

Good cause may be found when a physician or supplier claim-filing delay was due to:

- Incorrect or incomplete information is furnished by official sources (for example, carrier, intermediary, CMS) to the physician or supplier; this is considered an administrative error.
- Incorrect information is furnished by the member to the physician or supplier, resulting in erroneous filing with another managed care organization or with the state.
- An unavoidable delay in securing required supporting claim documentation or evidence from one or more third parties, despite reasonable efforts by the physician/supplier to secure such documentation or evidence.
- Unusual, unavoidable or other circumstances beyond the service provider's control that demonstrate the physician or supplier could not reasonably be expected to have been aware of the need to file timely.
- Destruction or other damage of the physician's or supplier's records, unless such destruction or other damage was caused by the physician's or supplier's willful act of negligence.

Clean Claims Payments

A clean claim is a request for payment for a service rendered by a provider that:

- Is submitted on time.
- Is accurate.
- Is submitted on a HIPAA-compliant standard claim form (CMS-1500, CMS-1450 (UB04) or successor forms).
- Requires no further information, adjustment or alteration to be processed and paid.
- Is not from a provider who is under investigation for fraud or abuse.
- Is not a claim under review for medical necessity.

HealthKeepers, Inc. will adjudicate clean claims to a paid or denied status within 30 calendar days of receipt for all claims. Claims related to Cardinal Care ARTS, mental health services (MHS), early intervention, nursing facilities, LTSS services, and doula services are required to be adjudicated within 14 days of receipt if the claims are deemed 'clean claims' (see below). If the claim is not paid within these time frames, HealthKeepers, Inc. will pay all applicable interest as required by law. See the following section for more information on clean claims for Cardinal Care members.

HealthKeepers, Inc. produces and mails an Explanation of Payment once per week, which shows the status of each claim that has been adjudicated during the previous claim cycle.

If HealthKeepers, Inc. does not receive all of the required information, HealthKeepers, Inc. will deny the claim either in part or in whole within 30 calendar days of receipt of the claim. A request for the missing information will appear on the EOP.

Once all requested information has been received, HealthKeepers, Inc. will process the claim within 30 calendar days.

HealthKeepers, Inc. will process clean claims from nursing facilities, LTSS (including when LTSS services are covered under EPSDT), ARTS, MHS, Early Intervention, and doula providers within 14 calendar days from receipt of the clean claim, as defined above, for covered services rendered to members enrolled in Cardinal Care plan at the time the service was delivered.

If the service is covered by Medicare, the 14-calendar day time frame begins after Medicare adjudication. If the member is enrolled with HealthKeepers, Inc. for both Medicare and Medicaid services, the claim will be adjudicated within 14-calendar days of receipt of a claim.

When the service is not covered by Medicare (for example, custodial nursing facility, most LTSS, community mental health, etc.), the 14-calendar day payment rule of receipt of a clean claim is applicable.

All individual practitioners providing Early Intervention services must be certified by the Department of Behavioral Health and Developmental Services (DBHDS) to provide Early Intervention services in accordance with 12 VAC 30-50-131.

Claims Status

Providers can check the status of claims by logging into **https://Availity.com** at **https://providers.anthem.com/va** or calling Anthem HealthKeepers Plus Provider Services at **800-901-0020.** Providers can also use the claims status information for accepted and rejected claims that were submitted through a clearinghouse.

If HealthKeepers, Inc. does not have a claim on file, providers must resubmit the claim within the timely filing requirements. If filing electronically, providers can check the confirmation reports received from the provider's electronic data interchange (EDI) or practice management vendor for acceptance of the claim.

Coordination of Benefits

If a member carries insurance through multiple insurers, HealthKeepers, Inc. will coordinate the benefits to ensure maximum coverage without duplication of payments. Providers must submit coordination of benefits (COB) claims to the primary carrier before submitting to HealthKeepers, Inc. After submitting the claim to the primary carrier, submit a claim for the total billed charges to HealthKeepers, Inc. along with a copy of the primary carrier's remittance advice. 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 remittance advice (RA)
- Third-party letter explaining either the denial of coverage or reimbursement

COB claims received without at least one of these items will be returned to the provider via mail with a request to submit to the other healthcare program first. Make sure the information submitted explains all coding listed on the other carrier's RA or letter. We cannot process the claim without this information.

Providers can submit secondary or tertiary claims through Availity Essentials by selecting **Secondary** or **Tertiary** in the Responsibility Sequence field on the Availity Essentials web claim form.

However, for services that are known to be noncovered under Medicare or commercial services, HealthKeepers, Inc. does not require providers to follow the above noted coordination of benefits processes. Examples of these services include, but are not limited to, LTSS waiver services such as personal care and respite care services. One exception is for private duty nursing (PDN) as these services are often covered through commercial insurance. However, HealthKeepers, Inc. only requires an EOB for PDN services if the commercial carriers cover all or part of PDN services.

Coordination of Benefits: Medicare Claims

CMS developed the Coordination of Benefits Agreement (COBA), which standardizes the way eligibility and Medicare claims payment information within a claims crossover context is exchanged. In accordance with our participation in this agreement, we submit our Medicaid enrollment data to CMS to obtain Medicare claim payment information. The exchange is used to create a claim to process coordination of benefits. The COBA allows greater efficiency and simplification via consolidation of the claims crossover

process; the provider does not need to submit any Medicare primary claim to the secondary carrier for reimbursement.

Coordination of Benefits, Third-party Liability and Blue Card Association
HealthKeepers, Inc. follows Virginia-specific guidelines when coordination of benefits is necessary. HealthKeepers, Inc. uses covered medical and hospital services whenever available or other public or private sources of payment for services rendered to Anthem HealthKeepers Plus members.

When third-party resources and third-party liability (TPL) resources are available to cover the costs of medical services provided to Medicaid members, HealthKeepers, Inc. will reject the claim and redirect providers to bill the appropriate insurance carrier (unless certain pay-and-chase circumstances apply; see below). Or, if HealthKeepers, Inc. is not aware of the resource until after payment for the service was rendered, HealthKeepers, Inc. will pursue post-payment recovery of the expenditure. Providers must not seek recovery in excess of the Medicaid payable amount.

The pay-and-chase circumstances are:

- When the services are for preventive pediatric care, including EPSDT.
- When a service is rendered to a child of an absent parent (that is, primary coverage is through a noncustodial parent after a divorce). This is provided that the payments have not been made by a third party within 100 days after such service is furnished.

HealthKeepers, Inc. has partnered with a subrogation vendor to handle the filing of liens and settlement negotiations both internally and externally.

Call Anthem HealthKeepers Plus Provider Services at **800-901-0020** with any questions regarding paid, denied or pended claims.

For children with commercial insurance coverage, providers must bill the commercial insurance first for covered early intervention services except for:

1. Those services federally required to be provided at public expense as is the case for:
    a. Assessment/early intervention evaluation.
    b. Development or review of the IFSP
    c. Targeted case management/service coordination.
2. Developmental services
3. Any covered early intervention services where the family has declined access to their private health/medical insurance.

Reimbursement Policies

Reimbursement policies serve as a guide to assist providers with accurate claims submissions and outline the basis for reimbursements when services are covered by

the member's Anthem HealthKeepers Plus plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that a provider will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure, diagnosis and the member's state of residence.

Providers must follow proper billing and submission guidelines and use industry standard, compliant codes on all claims submissions. Services should be billed with the CPT codes, HCPCS codes and/or revenue codes for the services and/or procedures performed; billed code(s) must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, HealthKeepers, Inc.'s policies apply to both participating and nonparticipating providers and facilities.

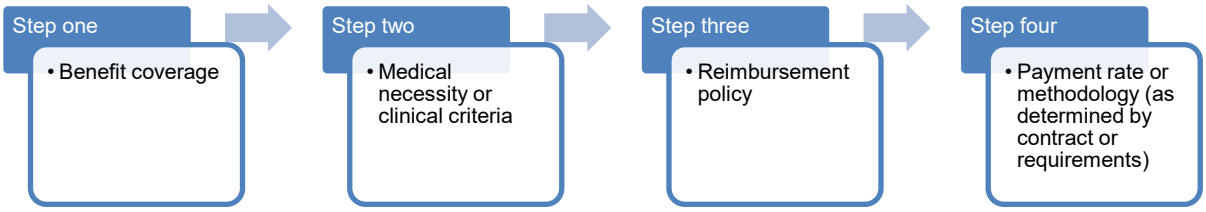
If appropriate coding/billing guidelines or current reimbursement policies are not followed,
we may:

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

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

HealthKeepers, Inc. reserves the right to review and revise policies when necessary. When there is an update, HealthKeepers, Inc. will publish the most current policies on the provider website under the **Claims** section. Because the *Fair Business Practices Act* does not apply to Medicaid business, HealthKeepers, Inc. is not required to notify providers in advance of changes to reimbursement policies.

Reimbursement Hierarchy
Claims submitted for payment 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 is considered a condition of payment.



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

Reimbursement by Code Definition
HealthKeepers, Inc. allows reimbursements for covered services based on their procedure code definitions or descriptors, as opposed to their appearance under particular CPT categories or sections, unless otherwise noted by state or provider contracts, or state, federal or CMS requirements. There are seven CPT sections:

- Evaluation and management
- Anesthesia
- Surgery
- Radiology (nuclear medicine and diagnostic imaging)
- Pathology and laboratory
- Medicine
- Temporary codes for emerging technology, services or procedures

At times, procedure codes are located in particular CPT categories when those procedures may not, as a general understanding, be classified within that particular category (for example, venipuncture is located in the CPT surgical section but is not considered to be a surgical procedure).

Outlier Reimbursement — Audit And Review Process

Requirements and Policies
This section includes guidelines on reimbursement to providers and facilities for services on claims paid by DRG with an outlier paid at percent of billed charge or where the entire claim is paid at percent of billed charge. Our vendor-partner or our internal team may review these claims as part of our itemized bill review (IBR) program to ensure appropriate reimbursement. Upon completion of the review, documentation, including a summary of adjusted charges, will be provided for each claim. Disputes

related to the review may be submitted according to the instructions in the Claims Payment Disputes section of this manual.

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

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

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

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

Emergency Room Supplies and Services Charges
The emergency room level reimbursement includes all monitoring, equipment, supply, time and staff charges. Reimbursement for the use of the emergency room includes the use of the room and personnel employed for the examination and treatment of patients. This reimbursement does not typically include the cost of physician services. See Facility Personnel Charges and Nursing Procedures sections for additional information.

Facility Personnel Charges
Charges for inpatient services for facility personnel are not separately reimbursable and the reimbursement for such is included in the room and board rate or procedure charge. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions (including IV or PICC line insertion at bedside),therapeutic, prophylactic, or diagnostic intravenous (IV) injections or infusion or IV fluid administration/monitoring, call back charges, nursing increments, therapy increments, and bedside respiratory and pulmonary function services, and chemotherapy infusion/administration/monitoring. Charges for outpatient services for facility personnel are also not separately reimbursable and are included in the reimbursement for the procedure or observation charge.

Implants
Implants are objects or materials which are implanted such as a piece of tissue, a tooth, a pellet of medicine, a medical device, a tube, a graft, or an insert placed into a surgically or naturally formed cavity of the human body to continuously assist, restore or replace the function of an organ system or structure of the human body throughout its useful life. Implants include, but are not limited to: stents, artificial joints, shunts, pins, plates, screws, anchors and radioactive seeds, in addition to non-soluble, or solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Instruments that are designed to be removed or discarded during the same operative session during which they are placed in the body are not implants. In addition to meeting the above criteria, implants must also remain in the member's body upon discharge from the inpatient stay or outpatient procedure.

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

IV Sedation and Local Anesthesia
Charges for IV sedation and local anesthesia administered by the provider performing the procedure, and/or nursing personnel, are not separately reimbursable and are included as part of the Operating Room (OR) time/procedure reimbursement. Charges for medications/drugs used for sedation and local anesthesia are separately reimbursable.

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

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

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

Nursing Procedures
Fees associated with nursing procedures or services provided by Facility nursing staff or unlicensed Facility personnel (technicians) performed during an inpatient (IP) admission or outpatient (OP) visit will not be reimbursed separately. Examples include, but are not limited, to therapeutic, prophylactic, or diagnostic intravenous (IV) injections

or infusion or IV fluid administration/monitoring, intramuscular (IM) injections, subcutaneous (SQ) injections, nasogastric tube (NGT) insertion, urinary catheter insertion, point of care/bedside testing (such as glucose, blood count, arterial blood gas, clotting time, pulse oximetry, etc.) and inpatient blood transfusion administration/monitoring and inpatient chemotherapy infusion/administration/monitoring (with the exception of OP blood administration, OP chemotherapy administration, or OP infusion administration which are submitted without a room charge, observation charges, treatment room charges, or procedure charges other than blood, chemotherapy, or infusion administration.)

Operating Room Time and Procedure Charges
The operating room (OR) charge will be based on a time or procedural basis. When time is the basis for the charge, it should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes. The Operating Room is defined as surgical suites, major and minor, treatment rooms, endoscopy labs, cardiac cath labs, Hybrid Rooms, X-ray, pulmonary and cardiology procedural rooms. The operating room charge will reflect the cost of:

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

Personal Care Items and Services
Personal care items used for patient convenience are not separately reimbursable. Examples include but are not limited to: breast pumps, deodorant, dry bath, dry shampoo, eye lubricants, lotion, non-medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, toothbrush, and toothpaste.

Pharmacy Charges
Pharmacy charges will be reimbursed to include only the cost of the drugs prescribed by the attending physician. Medications furnished to patients shall not include an additional separate charge for administration of drugs, the cost of materials necessary for the preparation and administration of drugs, and the services rendered by registered pharmacists and other pharmacy personnel. All other services are included in the drug reimbursement rate. Example of pharmacy charges which are not separately reimbursable include, but are not limited to: IV mixture fees, IV diluents such as saline and sterile water, IV Piggyback (IVPB), Heparin and saline flushes to administer IV drugs, and facility staff checking the pharmacy (Rx) cart.

Portable charges
Portable charges are included in the reimbursement for the procedure, test, or x-ray, and are not separately reimbursable.

Pre-operative Care or Holding Room Charges
Charges for a pre-operative care or a holding room used prior to a procedure are included in the reimbursement for the procedure and are not separately reimbursed. In addition, nursing care provided in the pre-operative care areas will not be reimbursed separately. Reimbursement for the procedure includes all nursing care provided.

Preparation (Set-Up) Charges
Charges for set-up, equipment, or materials in preparation for procedures or tests are included in the reimbursement for that procedure or test.

Recovery Room Charges
Reimbursement for recovery room services (time or flat fee) includes all used and/or available services, equipment, monitoring, and nursing care that is necessary for the patient's welfare and safety during their confinement. This will include but is not limited to cardiac/vital signs monitoring, pulse oximeter, medication administration fees, nursing services, equipment, supplies, (whether disposable or reusable), defibrillator, and oxygen. Separate reimbursement for these services will not be made.

Recovery Room Services Related to IV Sedation and/or Local Anesthesia
Separate reimbursement will not be made for a phase I or primary recovery room charged in connection with IV sedation or local anesthesia. Charges will be paid only if billed as a post procedure room or a phase II or step-down recovery room (for example, arteriograms).

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

Routine Supplies
Any supplies, items, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and supplies and not separately reimbursable in the inpatient and outpatient environments. Reimbursement for routine services and supplies is included in the reimbursement for the room, procedure, or observation charges.

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

Stand-by Charges
Standby equipment and consumable items such as oxygen, which are on standby, are not reimbursable. Only actual use is covered. Standby charges for facility personnel are included in the reimbursement for the procedure and not separately reimbursable.

Stat Charges
Stat charges are included in the reimbursement for the procedure, test, and/or X-ray. These charges are not separately reimbursable.

Supplies and Equipment
Charges for medical equipment, including but not limited to, IV pumps, PCA Pumps, isolation carts, mechanical ventilators, continuous positive airway pressure (CPAP)/ bilevel positive airway pressure (BIPAP) machines, and related supplies are not separately reimbursable. Oxygen charges, including but not limited to, oxygen therapy per minute/per hour when billed with room types ICU/CCU/NICU or any Specialty Care area are not separately reimbursable.

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

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

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

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

Video or Digital Equipment Used in Procedures
Charges for video or digital equipment used for visual enhancement during a procedure are included in the reimbursement for the procedure and are not separately reimbursable. Examples include but are not limited to Ultrasound and Fluoroscopy guidance including but not limited to, for access and/or placement of medical devices, implants, or lines. Charges for batteries, covers, film, anti-fogger solution, tapes etc., are not separately reimbursable.

Additional Reimbursement Guidelines for Disallowed Charges
For any Claims that are reimbursed at a percent of charge, only Charges for Covered Services are eligible for reimbursement. The disallowed charges (charges not eligible for reimbursement) include, but are not limited to, the following, whether billed under the specified revenue code or any other revenue code. These guidelines may be superseded by the Provider or Facility agreement. Refer to the contractual fee schedule for payment determination.

Examples of non-reimbursable items/services codes (including but not limited to):	
Typically billed under this/these revenue codes but not limited to the revenue codes listed below	**Description of excluded items**
0990 – 0999	Personal care items • Courtesy/hospitality room • Patient convenience items (0990) • Cafeteria, guest tray (0991) • Private linen service (0992) • Telephone, telegraph (0993) • TV, radio (0994) • Non-patient room rentals (0995) • Beauty shop, barber (0998) • Other patient convenience items (0999)
0220	Special charges
0369	Preoperative care or holding room charges

Examples of non-reimbursable items/services codes (including but not limited to):	
Typically billed under this/these revenue codes but not limited to the revenue codes listed below	**Description of excluded items**
0760 – 0769	Special procedure room charge
0111 – 0119	Private room* (subject to member's benefit)
0221	Admission charge
0480 – 0489	Percutaneous transluminal coronary angioplasty (PTCA) stand-by charges
0220, 0949	Stat charges
0270 – 0279, 0360	Video or digital equipment used in procedures
0270, 0271, 0272	**Supplies and equipment** • Blood pressure cuffs/stethoscopes • Thermometers, temperature probes, etc. • Pacing cables/wires/probes • Pressure/pump transducers • Transducer kits/packs • SCD sleeves/compression sleeves/ted hose • Oximeter sensors/probes/covers • Electrodes, electrode cables/wires • Oral swabs/toothettes; • Wipes (baby, cleansing, etc.) • Bedpans/urinals • Bed scales/alarms • Specialty beds • Foley/straight catheters, urometers/leg bags/tubing • Specimen traps/containers/kits • Tourniquets • Syringes/needles/lancets/butterflies • Isolation carts/supplies • Dressing change trays/packs/kits • Dressings/gauze/sponges • Kerlix/Tegaderm/Opsite/Telfa

Examples of non-reimbursable items/services codes (including but not limited to):	
Typically billed under this/these revenue codes but not limited to the revenue codes listed below	**Description of excluded items**
	• 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, 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

Examples of non-reimbursable items/services codes (including but not limited to):	
Typically billed under this/these revenue codes but not limited to the revenue codes listed below	**Description of excluded items**
0263	IV Infusion for therapy, prophylaxis (96365, 96366) IV Infusion additional for therapy IV Infusion concurrent for therapy (96368) IV Injection (96374, 96379)
0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310	Nursing procedures and 99001 – Handling and/or conveyance of specimen from patient (charge for specimen handling
0230	Incremental nursing – general
0231	Nursing charge – nursery
0232	Nursing charge – obstetrics (OB)
0233	Nursing charge – intensive care unit (ICU)
0234	Nursing charge – cardiac care unit (CCU)
0235	Nursing charge – hospice
0239	Nursing charge – emergency room (ER) or post anesthesia care unit (PACU) or operating room (OR)
0250 – 0259, 0636	**Pharmacy** • Medication prep • Nonspecific descriptions • Anesthesia gases – billed in conjunction with anesthesia time charges • IV solutions 250 cc or less, except for pediatric claims • Miscellaneous descriptions • Compounding fees
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	**Venipuncture** • Specimen collection • Draw fees

Examples of non-reimbursable items/services codes (including but not limited to):	
Typically billed under this/these revenue codes but not limited to the revenue codes listed below	**Description of excluded items**
	• Venipuncture • Phlebotomy • Heel stick • Blood storage and processing blood administration • Thawing/pooling fees
0270, 0272, 0300 – 0309	• Bedside/point of care/near patient testing (such as glucose, blood count, arterial blood gas, clotting time, etc.)
0222, 0270, 0272, 0410, 0460	Portable charges
0270 – 0279, 0290, 0320, 0410, 0460	**Supplies and equipment** • Oxygen • Instrument trays and/or surgical packs • Drills/saws (All power equipment used in O.R.) • Drill bits • 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

Examples of non-reimbursable items/services codes (including but not limited to):	
Typically billed under this/these revenue codes but not limited to the revenue codes listed below	**Description of excluded items**
	• 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 (Specifically, conscious/moderate sedation by same physician or procedure nurse)** • Nursing care • Monitoring • Intervention • Pre- or post-evaluation and education • IV sedation and local anesthesia if provided by same physician or procedure nurse • Intubation/extubation • CPR
0410	**Nursing Respiratory functions:** • Oximetry • Vent management • Medication administration via Nebs, metered dose (MDI), etc. • Postural drainage

Examples of non-reimbursable items/services codes (including but not limited to):	
Typically billed under this/these revenue codes but not limited to the revenue codes listed below	**Description of excluded items**
	• Suctioning procedure
0940 – 0945	Education/training

Billing Members

Before rendering a service that is not covered by HealthKeepers, Inc., providers must inform the member that HealthKeepers, Inc. does not cover the cost, and he or she will have to pay for the service. The member must sign a waiver that includes a detailed description of the services to be provided and an itemized accounting of all expected charges for which the member will be responsible. Pursuant to Section 1128B(d)(1) 42 U.S.C. 1320a-7b of the Social Security Act, a provider who knowingly and willfully bills a member for a Medicaid-covered service may be convicted of a felony and be subject to fines and/or imprisonment.

In accordance with Section 1932(b)(6) 42 U.S.C. § 1396u-2 (b)(6) and 42 C.F.R § 438.106(a)(b)(1)(2)(c) of the Social Security Act, a member can't be liable for:

- Any debts of HealthKeepers, Inc. in the event of insolvency.
- Payment for services provided by HealthKeepers, Inc. if HealthKeepers, Inc. hasn't received payment from DMAS for the services or if the provider, under contract or other arrangement with HealthKeepers, Inc., fails to receive payment from DMAS or HealthKeepers, Inc.
- Payments for covered services to providers, under a contract or other arrangement with HealthKeepers, Inc., that are in excess of the amount that normally would be paid by the member if the service had been received directly from HealthKeepers, Inc.

If a provider chooses to provide services that HealthKeepers, Inc. does not cover:

- HealthKeepers, Inc. only reimburses for services that are medically necessary, including hospital admissions and other services.
- Providers may not bill for or take recourse against a member for denied or reduced claims for services that are within the amount, duration and scope of benefits of the Medicaid program.

Providers cannot balance-bill for the amount above that which HealthKeepers, Inc. pays for covered services. Per Section 1932(b)(6) of the Social Security Act, HealthKeepers, Inc. requires that, for covered services, subcontractors and referral providers not bill members any amount greater than that which would be owed if the entity provided the services directly. In addition, providers may not bill a member if any of the following occurs:

- Failure to submit a claim on time, including claims not received by HealthKeepers, Inc.
- Failure to submit a claim to HealthKeepers, Inc. for initial processing within the timely filing deadline
- Failure to dispute a corrected claim within the clean-claim submission period
- Failure to appeal a claim within the 365-day payment reconsideration period
- Failure to appeal a utilization review determination within 60 days of notification of coverage denial
- Submission of an unsigned or otherwise incomplete claim
- Errors made by a provider in claims preparation, claims submission or the appeal/dispute process

Attempting to bill an Anthem HealthKeepers Plus member for any covered service is a breach of the provider's agreement and is grounds for termination.

High-Dollar Inpatient Claims Review

To help ensure consistency in facility claims review and reimbursement practices, HealthKeepers, Inc. collaborates with a third-party vendor to review Anthem HealthKeepers Plus facility claims that meet outlier charge thresholds.

Claims with payable charges of $100,000 or greater, with diagnosis-related group (DRG) outlier charges in excess of $2,500, will require an itemized bill to substantiate the outlier payment. If an itemized bill is not submitted with the claim, HealthKeepers, Inc. will pay the contracted DRG amount only, deny the outlier charge(s) and request an itemized bill through an explanation code on the explanation of payment. The explanation code will be "GMU" and the detailed description will read:
"Billed DRG contains outlier charges. For outlier consideration, submit an itemized bill to HealthKeepers, Inc.'s vendor."

If a provider receives a denial because he or she did not submit an itemized bill with a claim containing DRG outlier(s), he or she may email or fax HealthKeepers Inc.'s vendor. There is no need to submit a corrected claim with the itemized bill.

To expedite the review of the outlier payment, providers must submit the itemized bill directly to HealthKeepers, Inc.'s vendor.

If an outlier charge is determined to be appropriate, the outlier will be adjusted and payment will be issued. If an outlier charge is determined to be inappropriate, the outlier charge will be denied. HealthKeepers, Inc.'s vendor will send a written response with the outcome of the review. The response will include a direct contact with whom providers can discuss and resolve any issues. If providers disagree with the outcome of an outlier decision, they may submit a provider payment dispute request through the HealthKeepers, Inc. payment dispute process, as outlined in this manual.

Claim Payment Disputes

Provider Claim Payment Dispute Process

If you disagree with the outcome of a claim, you may begin the Anthem HealthKeepers Plus provider payment dispute process. The simplest way to define a claim payment dispute is when the claim is finalized, but you disagree with the outcome.

Please be aware there are three common, claim-related issues that are not considered claim payment disputes. To avoid confusion with claim payment disputes, we've defined them briefly here:

- Claim inquiry: a question about a claim but not a request to change a claim payment
- Claims correspondence: when HealthKeepers, Inc. requests further information to finalize a claim; typically includes medical records, itemized bills or information about other insurance a member may have
- Medical necessity appeals: a pre-service appeal for a denied service; for these, a claim has not yet been submitted

For more information on each of these, please refer to the appropriate section in this provider manual.

The Anthem HealthKeepers Plus provider payment dispute process consists of two internal steps and a third external step. You will **not** be penalized for filing a claim payment dispute, and no action is required by the member.

1. **Claim payment reconsideration:** This is the first step in the Anthem HealthKeepers Plus 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. **Providers are only allowed one claim payment reconsideration per claim.** If the provider disagrees with the outcome of the reconsideration, the provider should follow the process for claim payment appeal.
2. **Claim payment appeal:** This is the second step in the Anthem HealthKeepers Plus provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal. Providers are only allowed **one** claim payment appeal. If the provider

disagrees with the outcome of the appeal, the provider can submit an appeal to the Department of Medical Assistance Services (DMAS).

3. **Regulatory appeal:** DMAS supports an external review process if you have exhausted both steps in the Anthem HealthKeepers Plus payment dispute process but still disagree with the outcome.

A claim payment dispute may be submitted for multiple reason(s), including:

- Contractual payment issues.
- Disagreements over reduced or zero-paid claims.
- Post-service authorization issues.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Retro-eligibility issues.
- Experimental/investigational procedure issues.
- Claim data issues.
- Timely filing issues.*

* We will consider reimbursement of a claim that has been denied due to failure to meet timely filing if you can: 1) provide documentation the claim was submitted within the timely filing requirements or 2) demonstrate good cause exists.

Claim Payment Reconsideration

The first step in the Anthem HealthKeepers Plus claim payment dispute process is called the reconsideration. It is your initial request to investigate the outcome of a finalized claim. Please note, we cannot process a reconsideration without a finalized claim on file.

We accept reconsideration requests in writing, orally and through our secure provider website within 365 calendar days from the date on the *EOP* (see below for further details on how to submit). Reconsiderations filed more than 365 days from the *EOP* will be considered untimely and denied unless good cause can be established.

When submitting reconsiderations, please include as much information as you can to help us understand why you think the claim was not paid as you would expect. If a reconsideration requires clinical expertise, the appropriate clinical Anthem HealthKeepers Plus professionals will review it.

The Anthem HealthKeepers Plus plan requires providers to use our claims payment reconsideration process if you feel a claim was not processed correctly**.**

The Anthem HealthKeepers Plus plan will make every effort to resolve the claims payment reconsideration within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

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

- A statement of the provider's reconsideration request.
- A statement of what action the Anthem HealthKeepers Plus plan intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes or provider manual references.
- An explanation of the provider's right to request a claim payment appeal within 15 months of the date of service or 180 calendar days of the date you are notified of the reconsideration decision.
- An address to submit the claim payment appeal.

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

Claim Payment Appeal

If you are dissatisfied with the outcome of a reconsideration determination, you may submit a claim payment appeal. **Please note, we cannot process a claim payment appeal without a reconsideration on file.**

We accept claim payment appeals through our provider website or in writing **within 15 months of the date of service or 180 calendar days of the date you are notified of the reconsideration decision.**

Claim payment appeals received more than 15 months of the date of service or 180 calendar days of the date you are notified of the reconsideration decision will be considered untimely and upheld unless good cause can be established.

When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the reconsideration determination was in error. If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate Anthem HealthKeepers Plus clinical professionals.

The Anthem HealthKeepers Plus plan will make every effort to resolve the claim payment appeal within 60 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 60 additional

calendar days. We will mail you a written extension letter before the expiration of the initial 60 calendar days.

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

- A statement of the provider's claim payment appeal request.
- A statement of what action the Anthem HealthKeepers Plus plan intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes or provider manual references.

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

How to Submit a Claim Payment Dispute

We have several options to file a claim payment dispute:

- Orally (for reconsiderations only): Call Provider Services at **800-901-0020**.
- Online (for reconsiderations and claim payment appeals): Use the secure Provider Availity Essentials Payment Appeal Tool at **https://Availity.com**. Through Availity Essentials, you can upload supporting documentation and will receive immediate acknowledgement of your submission. You do not need to attach a *Claim Information/Adjustment Request 151 Form for Medicaid Claims* or a claim payment appeal form when using Availity Essentials.
- Written (for reconsiderations and claim payment appeals): Mail all required documentation (see below for more details), including the *Claim Information/Adjustment Request 151 Form for Medicaid Claims* to:

  HealthKeepers, Inc.
  Payment Appeals Unit
  P.O. Box 61599
  Virginia Beach, VA 23466-1599

Submit reconsiderations on the *Claim Information/Adjustment Request 151 Form for Medicaid Claims.* The *Claim Information/Adjustment Request 151 Form for Medicaid Claims* can be found on **www.anthem.com**. From menu at the top of the page, select **Providers** and then select **Provider Overview**. Select the **Find Resources for Your State** button and select **Virginia**. Select **Answers@Anthem** (top menu) and pick **Provider Forms.** From this page you can select the **Claim Information/Adjustment Request 151 Form for Medicaid Claims**.

Submit written claim payment appeals via a written letter.

Required Documentation for Claims Payment Disputes

Anthem HealthKeepers Plus providers are required to include the following information when submitting a claim payment dispute (reconsideration or claim payment appeal):

- Your name, address, phone number, email, and either your NPI or TIN
- The member's name and his or her Anthem HealthKeepers Plus or Medicaid ID number
- A listing of disputed claims, which should include the Anthem HealthKeepers Plus claim number and the date(s) of service(s)
- All supporting statements and documentation

State Appeal

A provider may appeal an adverse decision to DMAS where a service has already been provided. Before appealing to DMAS, providers must first exhaust all appeal processes through HealthKeepers, Inc.

If the claim payment appeal is denied, or a provider receives reduced reimbursement through the appeal process, he or she has exhausted the appeal rights. The final denial letter will state that the provider has exhausted Anthem HealthKeepers Plus appeal rights and that the next level of appeal is with the Department of Medical Assistance Services (DMAS). It will also include the standard DMAS appeal rights, including the time period and address to file the appeal. The appeal to DMAS is considered the third and final appeal.

The appeal must be filed with the DMAS Appeals Division through one of the following methods:

- Through the Appeals Information Management System at **https://www.dmas.virginia.gov/appeals**. From there you can fill out an informal appeal request, submit documentation, and follow the process of your appeal.
- Through mail, email, or fax. You can download a Medicaid Provider Appeal Request form at **https://www.dmas.virginia.gov/appeals**. You can use that form or a letter to file the informal appeal. The appeal request must identify the issues being appealed. The request can be submitted by:
  - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
  - Email to **appeals@dmas.virginia.gov**; or
  - Fax to 804-452-5454.

The appeal must be received by the DMAS Appeals Division within 30 days of the receipt of this final decision letter. The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The normal business hours of DMAS are from 8:00 a.m. through 5:00 p.m. on dates when DMAS is open for business. Documents received after 5:00 p.m. on the deadline date shall be untimely.

Claim Inquiries

A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but the outcome of the claim inquiry may result in the initiation of the claim payment dispute. In other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

Our Provider Experience program helps you with claim inquiries. Just call **800-901-0020** (Cardinal Care) and select the Claims prompt within our voice portal. We will connect you with a dedicated resource team, called the Provider Service Unit (PSU), to ensure:

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact, issue resolution rates.
- Significantly improved turnaround time of inquiry resolution.
- Increased outreach communication to keep you informed of your inquiry status.

The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue.

Claim Correspondence

Claim correspondence is different from a payment dispute. Correspondence is when HealthKeepers, Inc. requires more information to finalize a claim. Typically, HealthKeepers, Inc. makes the request for this information through the EOP. The claim or part of the claim may, in fact, be denied, but it is only because more information is required to process the claim. Once the information is received, HealthKeepers, Inc. will use it to finalize the claim.

The following table provides examples of the most common correspondence issues along with guidance on the most efficient ways to resolve them.

Type of Issue	What Do I Need to Do?
Rejected Claim(s)	Use the EDI Hotline at **800-590-5745** when your claim, submitted electronically, was rejected. For assistance with setup questions and help resolving submission issues or electronic claims rejections, contact Availity Client Services at **800-282-4548.**
EOP Requests for Supporting Documentation (Sterilization/ Hysterectomy/Abortion Consent Forms, Itemized Bills and Invoices)	Use Digital Request for Additional Information (Digital RFAI) process on **https://Availity.com** Submit a copy of your EOP and the supporting documentation to: Claims Correspondence P.O. Box 61599

Type of Issue	What Do I Need to Do?
	Virginia Beach, VA 23466-1599
EOP Requests for Medical Records	Submit a copy of your EOP and the medical records to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
Need to Submit a Corrected Claim due to Errors or Changes on Original Submission	Submit your corrected claim to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599 Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received timely, a corrected claim must be received within 365 days of the date of service. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to HealthKeepers, Inc. to adjust the other health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI EOB.
Submission of Coordination of Benefits (COB)/Third-Party Liability (TPL) Information	Submit a copy of your EOP and the COB/TPL information to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
Emergency Room Payment Review	Submit a copy of your EOP and the medical records to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599

Medical Necessity Appeals

Medical necessity appeals refer to a situation in which an authorization for a service was denied prior to the service. Medical necessity appeals/prior authorization appeals are different than claim payment disputes and should be submitted in accordance with the medical necessity appeal process.

Corrected Claims

A claim is considered a corrected claim when there are data changes to the original submission. If there is a need to modify a paid/finalized claim that was paid according to the information originally submitted, the corrections must be submitted on the applicable claim form.

Corrected claims must be received within 12 months of the adjudication of the original claim/date of the EOP. Requests for claims corrections cannot be submitted on a 151 Claim Information/Adjustment Request form.

Corrected claims may be submitted by mailing the proper claim form or on the provider website.

Written Corrected Claims

Mail written corrected claims to:
HealthKeepers, Inc.
P.O. Box 62404
Virginia Beach, VA 23466-2404

Electronic Corrected Claims

To file a corrected claim, go to **https://Availity.com** and:

1. Select Claims & Payment/Professional Claim or Facility Claim.
2. Fill in required fields (for details on claims inquiry, search “submitting claims” within Availity Essentials Help).
3. Select **Replacement of a prior claim** in the *Billing Frequency* field under the *Claim information* section of the Availity Essentials web claim form.

Note: When submitted, a corrected claim form must be indicated as such. On a CMS-1500, box 22 — Resubmission code and on a CMS-1450 (UB04), box 4 — Bill type must be completed by including the number 7, identifying the claim as a replacement to the previous submission.

Providers should stamp or handwrite on the claim "Corrected" or "Corrected Claim" to indicate a correction was made to a previously submitted and adjudicated claim (or the provider may physically stamp a claim as being a corrected claim).

For additional assistance, call Anthem HealthKeepers Plus Provider Services at **800-901-0020** Monday through Friday from 8 a.m. to 8 p.m. ET.

Claims Overpayment Recovery Process

Refund notifications may be identified by two entities, HealthKeepers, Inc. Cost Containment Unit (CCU) or the provider. The CCU researches and notifies the provider of an overpayment requesting a refund check. The provider may also identify an

overpayment and proactively submit a refund check to reconcile the overpayment amount.

Once an overpayment has been identified by HealthKeepers, Inc., CCU will notify the provider of the overpayment. The provider will have the option to submit a Refund Notification Form along with the refund check or have the overpayment offset from future claim payments. If a provider identifies the overpayment or returns the HealthKeepers, Inc. check, a completed Refund Notification Form specifying the reason for the return must be included. The claim information must be submitted with this form. This form can be found on the provider website at **http://providers.anthem.com/va**. The submission of the Refund Notification Form will allow the CCU to process and reconcile the overpayment in a timely manner. If a Refund Notification Form is not available, the provider can submit the refund check with a letter. The letter should include the following:

1. Provider name/contact
2. Contact number
3. Provider ID
4. Provider Tax ID
5. Subscriber ID
6. Member Name
7. Member Account Number
8. Date of Service
9. Total Billed Charges
10. Total Check Amount
11. Claim number(s)
12. Reason for refund or check return
13. Received an Overpayment Notification Letter
14. Contract rate change
15. Duplicate payment
16. Incorrect member
17. Incorrect provider
18. Negative Balance
19. Other Health Insurance (OHI) / Third-party liability (TPL)
20. Payment error
21. Billed in error / adjusted charge
22. Or other reason

In instances where we are required to adjust previously paid claims to adhere to a new published rate, we will initiate a reconciliation of the affected claims. As such, we will determine the cumulative adjusted reimbursement amount based on the new rates. In the event the outcome of this reconciliation results in a net amount owed to us, we will commence recovery of such amounts through an offset against future claims payments.

Such recoveries are not considered part of the overpayment recovery process described above or in the provider agreement.

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

Cost Containment Overpayment Disputes
As indicated in the HealthKeepers, Inc. refund request letter, provider overpayment refunds not received and applied within the timeframe indicated will result in claim recoupment from any claim the provider submits to HealthKeepers, Inc.

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

The mailing address and fax number are:
Cost Containment - Disputes
P.O. Box 62427
Virginia Beach, VA. 23466-2437
Fax: **866-920-1874**

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

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

Cost Containment
P.O. Box 933657
Atlanta, GA. 31193-3657

What does this mean for you?
The provision directly links the retention of overpayments to false claim liability. The language of 42 U.S.C.A. § 1320a-7k makes explicit that overpayments must now be reported and returned to states or respective MCOs within 60 days of identification of the overpayment or by the date any corresponding cost report is due, whichever is later. After 60 days, the overpayment is considered a false claim, which triggers penalties under the False Claims Act, including treble damages. To avoid such liability, healthcare providers and other entities receiving reimbursement under Medicare or Medicaid should implement policies and procedures on reporting and returning overpayments that are consistent with the requirements in the PPACA.

The provision entitled “Reporting and Returning Overpayments – Deadline for Reporting and Returning Overpayments,” codified at 42 U.S.C.A. § 1320a-7k, clarifies the uncertainty left by the 2009 Fraud Enforcement and Recovery Act.

This provision of the Health Care Reform Act applies to providers of services, suppliers, Medicaid managed care organizations, Medicare Advantage organizations and Medicare Prescription Drug Program sponsors. It does not apply to beneficiaries.

CHAPTER 12: MEMBER TRANSFERS AND DISENROLLMENT

Overview

Members have the freedom to choose their most important link to quality healthcare: their doctor. HealthKeepers, Inc. strongly encourages members to select a PCP and remain with that provider for the positive impact of having a medical home. This home establishes a centralized hub from which all healthcare can begin and can be coordinated, no matter how many other caregivers become involved. Occasionally, members may encounter barriers to effective relationships with their PCP, such as cultural and language difficulties, geographical access, or simply personal preferences. Members who want to change their PCP may do so at any time, for any reason.

Members also have the right to change healthcare plans during open enrollment and at any time for cause as explained below. HealthKeepers, Inc. notifies PCPs of member transfers through monthly enrollment reports. PCPs can find these reports online through the secure website at **https://providers.anthem.com/va** or by calling Anthem HealthKeepers Plus Provider Services at **800-901-0020**. The effective date of a PCP transfer will be the same as the date of the member request.

HealthKeepers, Inc. is committed to supporting providers' practices as well. Providers have the right to request a member is reassigned to another PCP under certain conditions and following specific guidelines.

State Agency Member Enrollment/Disenrollment

DMAS has sole responsibility for determining an individual's eligibility for Medicaid-funded services. DMAS informs HealthKeepers, Inc. of membership changes by sending regular enrollment reports. These reports contain all active membership data and incremental changes to eligibility records. HealthKeepers, Inc. disenrolls members who are not listed on the monthly DMAS enrollment file, effective as of the designated disenrollment date for the following reasons:

- Death
- Loss of benefits
- Member has other nongovernment or government-sponsored health coverage
- Member meets one of the DMAS exclusion criteria

Member-Initiated PCP Transfers

Members have the right to change their PCP at any time. When a member enrolls in HealthKeepers, Inc. programs, they can choose a PCP or allow their PCP to be assigned. If they want to make a change after that, members are instructed to call Member Services to request an alternate PCP, or a new PCP can be selected through the online member portal.

HealthKeepers, Inc. accommodates member requests for transfers whenever possible. Representatives work with the member to make the new selection, focusing on special needs. HealthKeepers, Inc. 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 representative will do so. If the PCP is not available, the representative will assist the member in finding an available PCP.
- If the member advises that he or she is hospitalized, the PCP change will take effect upon discharge.
- PCPs are notified of member transfers through monthly enrollment reports. PCPs can request these reports by calling Provider Services.
- The effective date of a PCP transfer will be the same as the date of the member request. HealthKeepers, Inc. may assign a member retroactively.
- To support member transfers, PCPs are encouraged to maintain open panels. An open panel is the commitment to accept new Anthem HealthKeepers Plus members.

Note: Providers can request members be transferred to a different PCP, but the provider has to provide evidence to HealthKeepers, Inc. that it has attempted to contact the member in writing before HealthKeepers, Inc. will consider the request. HealthKeepers, Inc. will not move members to another PCP based solely on a provider's request.

Member Transfers to Other Plans

During the first 90 calendar days following the effective date of enrollment, members may elect to change health plans for any reason. After their first 90 days of enrollment, members can choose a different managed care organization (MCO) on an annual basis during the open enrollment period. As required by federal regulations, this open enrollment period lasts for 90 calendar days. After the open enrollment period ends, members may not switch MCOs except for cause, as explained below. As required by federal regulations, this open-enrollment period lasts for 90 calendar days. After the open-enrollment period ends, members may not switch MCOs

Members remain with their chosen MCO for the remaining 12-month period after this occurs. To change MCOs at their annual redetermination period, the member may call the enrollment broker.

However, members retain the right to change their MCO at any time when they have "just cause," which can be any of the following (as determined by DMAS):

- Lack of access to necessary services covered under the MCO's contract (this does not include enhanced services)

- Lack of access to providers experienced in dealing with healthcare needs
- MCO does not, for moral or religious objections, cover the services the member seeks
- Member concerns over quality of care
- Member needs related services performed at the same time, and not all related services are available within the MCO's network
- Member's PCP leaves the MCO and participates with another MCO under contract with Virginia (so long as the member requests transfer to that MCO)

Members can call the enrollment broker at **800-643-2273** to learn how to choose a new MCO.

Members can also go online to **www.coverva.org** or call **855-242-8282**.

CHAPTER 13: GRIEVANCES AND APPEALS

Overview

HealthKeepers, Inc. encourages providers and members to seek resolution of issues through the grievances and appeals process. Grievances and appeals are tracked and trended, resolved within established time frames and referred to peer review when needed. The grievance and appeals process meets all requirements of state law and accreditation agencies.

Medical Necessity Appeals

HealthKeepers, Inc. affords providers one level of medical necessity appeal which is considered a formal appeal. Re-reviews are considered an informal process afforded to the provider on behalf of the member to dispute an adverse decision. A member, a member's authorized representative or a provider acting on behalf of a member with member's written consent may file an appeal. Although medical necessity criteria, such as Milliman, are reviewed with each level of care request, these items are only guidelines and just one factor that is considered in level of care medical necessity reviews. Because each level of care review represents a unique clinical scenario that may not be fully described by the above mentioned guidelines, other considerations, including but not limited to things such as practice patterns and professional experience and judgement, may also be factored into each final level of care medical necessity determination.

Medical Necessity Appeals — Formal Appeals

A member, a member's authorized representative or a provider acting on behalf of a member with member's written consent may file an appeal. The following time frames apply for appeal of standard service authorization decisions:

- Anthem HealthKeepers Plus members must file an appeal, either orally or in writing, within 60 calendar days of the date on the notice of action.
- FAMIS members must file within 60 calendar days from the date on the notice of action. This also applies to a member's request for an expedited appeal.
- For an appeal for termination, suspension or reduction of previously authorized services when the member requests continuation of such services, the member must file an appeal within 10 calendar days of the mailing date of the notice of action.

The goal is to handle and resolve every appeal as quickly as the member's health condition requires. Established time frames are:

- **Standard resolution of appeal and for appeals for termination, suspension or reduction of previously authorized services:** 30 calendar days from the date of receipt of the appeal, unless HealthKeepers, Inc., the member or DMAS approves an extension of 14 calendar days is necessary to complete the appeal. If

HealthKeepers, Inc. approves the extension, HealthKeepers, Inc. will send the provider a letter explaining the reason for the extension.

- **Expedited resolution of appeal, including notice to the affected parties:** as expeditiously as the medical condition requires, but no later than 72 hours from receipt of the appeal. The notice of the resolution of the appeal will be in writing. For notice of an expedited resolution, HealthKeepers, Inc. also makes reasonable efforts to provide prompt oral notice. Notice will include the date completed and reasons for the determination, in easily understood language. A written statement of the clinical rationale for the decision, including how the requesting provider or member may obtain the utilization management clinical review or decision-making criteria, will be issued.

HealthKeepers, Inc. makes every reasonable effort to give the member or his or her representative oral notification and follow up with written notification.

Members receive the results of the resolution in a written notice within 30 calendar days of receipt of the appeal. The notice will include:

- The date completed.
- The date the member's internal appeal was received.
- Reasons for the determination in easily understood language.
- A written statement of the clinical rationale for the decision, including how the requesting provider or member may obtain the utilization management clinical review or decision-making criteria.
- Whether or not an extension was granted and who requested it.

If an appeal is not wholly resolved in favor of the member, the notice will include:

- The right for the member to request a state fair hearing, and how to do so
- The right to receive benefits while this hearing is pending and how to request them
- Notice that the member may have to pay the cost of these benefits if the state fair hearing officer upholds the HealthKeepers, Inc. action

Expedited Appeals

The expedited appeal process is available upon member request. It also available when a provider indicates a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function. The member or provider may file an expedited appeal either orally by calling **800-901-0020** or in writing. Expedited appeals should be sent to:

HealthKeepers, Inc.
Grievance and Appeals Department
P.O Box 62509
Virginia Beach, VA 23466-2509

email: VAMedicaidAppeals@anthem.com
fax: **855-832-7294**

HealthKeepers, Inc. informs the member of the limited time he or she has to present evidence and allegations of fact or law with expedited resolution. HealthKeepers, Inc. also ensures no punitive action will be taken against a provider who supports an expedited appeal.

HealthKeepers, Inc. will resolve each expedited appeal and provide notice to the member as quickly as the member's health condition requires, but no later than 72 hours after receipt of the expedited appeal request.

HealthKeepers, Inc. will make reasonable efforts to give the members prompt oral notice of denials and follow up within two calendar days with written notices. Members have the right to file a grievance regarding a denial of a request for expedited resolution; members are informed of this right in the notice of denial.

Provider Appeals to DMAS

If a provider has rendered services to a member enrolled with HealthKeepers, Inc. and has either been denied authorization/reimbursement for the services or has received reduced authorization/reimbursement, that provider can request a reconsideration of the denied or reduced authorization/reimbursement. Before appealing to DMAS, providers must first exhaust HealthKeepers, Inc.'s reconsideration process.

Once a provider has exhausted its appeals rights with HealthKeepers, Inc., the provider must file the appeal with the DMAS Appeals Division through one of the following methods:

- Through the Appeals Information Management System at **https://www.dmas.virginia.gov/appeals**. From there you can fill out an informal appeal request, submit documentation, and follow the process of your appeal.
- Through mail, email, or fax. You can download a Medicaid Provider Appeal Request form at **https://www.dmas.virginia.gov/appeals**. You can use that form or a letter to file the informal appeal. The appeal request must identify the issues being appealed. The request can be submitted by:
  - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
  - Email to **appeals@dmas.virginia.gov**; or
  - Fax to 804-452-5454.

The appeal must be received by the DMAS Appeals Division within 30 days of the receipt of this final decision letter. The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The normal business hours of DMAS are

from 8 a.m. through 5 p.m. on dates when DMAS is open for business. Documents received after 5 p.m. on the deadline date shall be untimely.

State Fair Hearing Process (Cardinal Care)

The state fair hearing process is available to Cardinal Care members. The member or the member's authorized representative may request a hearing; a provider may not request a hearing on a member's behalf unless the member deems, in writing, the provider as his or her authorized representative.

The member may request a state fair hearing from DMAS after exhausting their appeal rights with HealthKeepers, Inc.

The request for a state fair hearing may be requested orally or in writing and be signed within 120 days of receipt of the HealthKeepers, Inc., appeal resolution letter.
When a hearing is requested, HealthKeepers, Inc. will provide DMAS and the member, upon request, all HealthKeepers, Inc.-held documentation related to the appeal, including but not limited to any transcript(s), records or written decision(s) from participating providers or delegated entities.

Implementation of a hearing decision may not be the basis for termination of enrollment by HealthKeepers, Inc.

HealthKeepers, Inc. will assist providers with filing state fair hearings if needed.

External Review (FAMIS)

If a FAMIS member does not agree with an appeal decision, they will need to file a request for an external review within 30 calendar days of receipt of the HealthKeepers, Inc. written appeal decision. Requests can be filed through the Acentra website at **https://atrezzo.kepro.com/ExternalReview.aspx** or by mail to:

FAMIS External Review
c/o Acentra
6802 Paragon Place, Suite 440
Richmond, VA 23230

This option is only available when the HealthKeepers, Inc. appeal process has been exhausted.

Continuation of Benefits during Appeals or State Fair Hearings

HealthKeepers, Inc. is required to continue a member's benefits while the appeals process or the state fair hearing is pending if all of the following are true:

- The appeal is submitted to HealthKeepers, Inc. on or before the latter of the two:

- Within 10 calendar days of the mailing date of the notice of action
- The intended effective date of the Anthem HealthKeepers Plus proposed action
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment
- Services were ordered by an authorized provider
- The original period covered by the original authorization has not expired
- The member requests an extension of benefits

If the decision is against the member, HealthKeepers, Inc. may recover the cost of the services the member received while the appeal was pending.

Member Grievances

Members have the right to say they are dissatisfied with HealthKeepers, Inc. or a provider's service and operations. A member, member's representative or provider may file a grievance with HealthKeepers, Inc. at any time. **Providers who file a grievance on behalf of a member require written approval from the member they represent.**

A member can file a grievance orally by calling Anthem HealthKeepers Plus Member Services at **800-901-0020** or by mail, including all supporting documents, to:

HealthKeepers, Inc.
P.O. Box 62509
Virginia Beach, VA 23466-2509

HealthKeepers, Inc. is responsible for properly responding to all grievances. Grievances will be acknowledged within five calendar days of receipt. A letter with a decision will be sent within 90 calendar days from the date HealthKeepers, Inc. received the grievance. If the member is not happy with the grievance decision, they have the right to file a complaint with the DMAS Managed Care Helpline at **800-643-2273**.

Member grievances do not involve:
- Medical management decisions
- Interpretation of medically necessary benefits
- Adverse determinations

These are called appeals and are addressed in the **Appeals** section above. HealthKeepers, Inc. will acknowledge receipt of appeals, in writing, within five business days.

Provider Grievance Procedure

To file a grievance, providers can call Anthem HealthKeepers Plus Provider Services at **800-901-0020**.

CHAPTER 14: CREDENTIALING AND RECREDENTIALING

Introduction

The credentialing requirements for Anthem HealthKeepers Plus providers follow the credentialing requirements for all lines of business and products offered by HealthKeepers, Inc. HealthKeepers, Inc. does not have credentialing requirements for Medicaid or FAMIS that are separate and distinct from other HealthKeepers, Inc. products, unless specifically required by HealthKeepers, Inc.'s contract with DMAS.

To see the credentialing requirements, go to **Appendix A** of this manual.

HealthKeepers, Inc. has implemented necessary requirements to comply with Virginia General Assembly's **House Bill (HB) 822** that became effective July 1, 2020. If you are a new provider applicant under credentialing review for participation in provider networks offered by HealthKeepers, Inc., HB 822 will allow you to see Anthem HealthKeepers Plus members and retroactively receive payments if you are ultimately credentialed.

This means that as of July 1, 2020, if you are a provider who submits a completed credentialing application to us, HealthKeepers, Inc. will adhere to the requirements specified in HB 822. Requirements in the bill do not apply to credentialing applications submitted **before** July 1, 2020, but only to applications that are still in the credentialing review process after the July effective date.

The law has established protocols and procedures for reimbursing new provider applicants at the contracted in-network rate for approved, covered services provided during the period in which a provider's credentialing application is pending. Effective July 1, 2020, under HB 822, the credentialing period begins with the receipt of a completed credentialing application. Incomplete credentialing applications and denied applications are excluded.

Hold claims for Anthem HealthKeepers Plus members:
During the credentialing period, providers **are required to hold claims** for our members until HealthKeepers, Inc. sends a final notification of a credentialing decision. If you submit claims to HealthKeepers, Inc. during the credentialing period before receiving a credentialing decision, claims for the impacted lines of business noted above will be rejected or denied indicating that the claims must be resubmitted upon a final credentialing decision. Members will be protected from inappropriate billing and held harmless during this period.

Patient financial responsibility:
Providers with approved credentialing applications are required to submit claims under their contract with HealthKeepers, Inc. For denied applications, no claims will be paid for services

rendered on behalf of Anthem HealthKeepers Plus members, and providers may not bill any Anthem HealthKeepers Plus members for any outstanding balances.

Notify Anthem HealthKeepers Plus members as required by HB by § 38.2-3407.10:1
In order to submit claims pursuant to HB 822, providers are required to take the following actions regarding members enrolled in health benefit plans offered by HealthKeepers, Inc.:

- Notify members — either in writing or electronically — stating that the provider's credentialing application has been submitted to HealthKeepers, Inc. and is under review.
- Provide the notice in advance of providing treatment to members.

Include in the notice to members certain credentialing information as outlined in HB 822.

Please refer to the **legislation** for actual requirements and how they impact you.

Questions
If you have questions about the status of your credentialing application, please email our credentialing area at credentialing@anthem.com. All other questions about the credentialing process should be directed to your Anthem HealthKeepers Plus network manager.

CHAPTER 15: ACCESS STANDARDS AND ACCESS TO CARE

Overview

This chapter outlines HealthKeepers, Inc. standards for timely and appropriate access to quality healthcare. Following guidelines set by the National Committee for Quality Assurance (NCQA), the American College of Obstetricians and Gynecologists (ACOG), and the Department of Medical Assistance Services (DMAS), 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.

HealthKeepers, Inc. recognizes there can be cultural and linguistic barriers that affect members' ability to understand or comply with certain instructions or procedures. In order to break through those barriers, HealthKeepers, Inc. encourages providers to review the ***Cultural Competency Toolkit***, which can be found on the provider website at **https://providers.anthem.com/va**.

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

Medical Appointment Standards

General Appointment Scheduling

PCPs and specialists must make appointments for members as follows:

Nature of visit	Appointment standards
Emergency examinations	Immediate access during office hours
Urgent examinations	Within 24 hours of request
Nonurgent sick visits	Within 72 hours of request
Nonurgent routine exams*	Within 30 days of request
Specialty care examinations	Within 3 weeks of request
Outpatient behavioral health examinations	Within 14 days of request
Routine behavioral health visits	As expeditiously as the member's condition requires. Within 5 business days from determination that coverage criteria is met
Outpatient treatment	Within 7 days of discharge
Post-psychiatric inpatient care	Within 7 days of discharge
LTSS services	As expeditiously as the member's condition requires; within 5 business days

Nature of visit	Appointment standards
	from determination that coverage criteria is met
Maternity	First trimester: Within 7 calendar days of request Second trimester: Within 7 calendar days of request Third trimester: Within 3 business days of request (Cardinal Care); High-risk pregnancies: Within 3 business days of high-risk identification Immediately if an emergency exists

* When the PCP's capacity is temporarily limited, exceptions are permitted for routine cases (other than clinical preventive services).

Members 21 Years of Age and Under

HealthKeepers, Inc. strongly recommends PCPs perform an initial health assessment (IHA) and preventive care assessment with new members. PCPs and specialists must make appointments for members as follows:

Nature of visit	Appointment standards
Initial health assessments	• Newborns: within 14 days of enrollment • Children: within 60 days of enrollment • Adults (18 to 21): within 8 weeks of enrollment
Preventive care visits	According to the American Academy of Pediatrics (AAP) Periodicity Schedule, found within the preventive health guidelines (PHG)

Members Over 21 Years of Age

Nature of visit	Appointment standards
Initial health assessments	Within 60 days of enrollment

Initial Health Assessments for Cardinal Care Members

Population	Appointment standards
Cardinal Care and EPSDT Populations	Within 14 calendar days for members who receive private duty nursing services

Population	Appointment standards
	Within 30 calendar days for members who do not receive private duty nursing services
Nursing facility Cardinal Care and other vulnerable Cardinal Care populations	Within 60 calendar days
Behavioral health populations	Within 5 business days from the date HealthKeepers, Inc. verifies member coverage.
LTSS populations	Within 5 business days from the date HealthKeepers, Inc. verifies member coverage.

Prenatal and Postpartum Visits

Nature of visit	Anthem HealthKeepers Plus appointment standards
First trimester	Within 7 days of request
Second trimester	Within 7 days of request
Third trimester	Within 3 business days of request or immediately if an emergency
High-risk pregnancy	Within 3 business days of request or immediately if an emergency
Postpartum exam	Between 1 and 12 weeks after delivery

Missed Appointment Tracking

When members miss appointments, providers must do the following:

1. Document the missed appointment in the member's medical record.
2. Make at least three attempts to contact the member to determine the reason for the missed appointment.
3. Provide a reason in the member's medical record for any delays in performing an examination, including any refusals by the member.

After-Hours Services

Members have access to quality healthcare 24 hours a day, 7 days a week. That means PCPs must have a system in place to ensure that members can call after-hours with medical questions or concerns. HealthKeepers, Inc. 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 after-hours protocols below.

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 them within 30 minutes.

- Ask the member if the call is an emergency. In the event of an emergency, they must immediately direct the member to dial **911** or proceed directly to the nearest hospital emergency room.
- Have the ability to contact a telephone interpreter for members with language barriers.
- Return all calls.

Members can also call the 24/7 NurseLine to speak to a registered nurse. Nurses provide health information and options for accessing care, including emergency services if appropriate.

Answering machine messages:

- May be used in the event that staff or an answering service is not immediately available.
- Must instruct members with emergency healthcare needs to dial **911** or proceed directly 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.

Note: HealthKeepers, Inc. prefers PCPs use an in-network provider for on-call services. When that is not possible, the PCP must use his or her best efforts to help ensure that the on-call provider abides by the terms of the provider contract.

Time and Distance Standards

HealthKeepers, Inc. follows the below time and distance standards for medical appointments:

Standard	Distance	Time
Urban: 1. PCPs, Adult 2. Pediatricians 3. Other Providers Including Specialists (see reporting requirements in the Cardinal Care Technical Manual).	 15 Miles 15 Miles 30 Miles	 30 Minutes 30 Minutes 45 Minutes
Rural: 1. PCPs, Adult 2. Pediatricians 3. Other Providers Including Specialists (see reporting requirements in the Cardinal Care Technical Manual	 30 Miles 30 Miles 60 Miles	 45 Minutes 45 Minutes 75 Minutes
*All zip codes for the regions of Southwest and Roanoke/Alleghany are considered rural.		

Continuity of Care

HealthKeepers, Inc. provides continuity of care for members with qualifying conditions when a member has an existing provider-patient relationship with a provider who is terminating their agreement or when the member or provider is in a state of transition.

Qualifying conditions include, but are not limited to:

- Acute conditions (for example, cancer)
- Degenerative and disabling conditions (including conditions or diseases caused by a congenital or acquired injury or illness that require a specialized rehabilitation program or high level of service, resources or coordination of care in the community)
- Pregnancy (with 12 weeks or less remaining before the expected delivery date through the first 60 calendar days of postpartum care)
- Serious chronic conditions (for example, hemophilia)
- Terminal illness

States of transition include:

- The member is hospitalized on the effective date of transition.
- The provider’s contract terminates.

HealthKeepers, Inc. 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, HealthKeepers, Inc. helps coordinate care when the provider's contract has been discontinued to help with a smooth transition to a new provider.

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

- Consultations
- Prior authorizations
- Referrals to specialists
- Treatment plans

Care 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 practitioner. As part of the coordination process, all providers share responsibility in communicating clinical findings, treatment plans, prognosis and the member’s psychosocial condition.

Adverse determination decisions are sent in writing to the member and provider within two business days of the decision. Members and providers can appeal the decision by

following the procedures in the **Grievances and Appeals** chapter. Appeal rights are also attached to the notice of adverse benefit determination letter for your reference. Reasons for continuity of care denials include, but are not limited to:

- Course of treatment is complete.
- The member is ineligible for coverage.
- The member does not have a qualifying condition.
- The request is for change of PCP only, and not for continued access to care.
- Requested services are not a covered benefit.
- Services rendered are covered under a global fee.

Note: HealthKeepers, Inc. does not impose any pre-existing condition limitations on its members, nor require evidence of insurability to provide coverage to any member.

Provider Contract Termination

HealthKeepers, Inc. will arrange for continuity of care for members affected by a terminated provider. A terminated provider who is actively treating members must continue to treat members until the date of termination. PCPs and specialists must give at least 120 days advance notice to HealthKeepers, Inc. before terminating the agreement.

Once a provider's notice to terminate a contract is received, HealthKeepers, Inc. will make the best effort to notify all impacted members. A letter will be sent within 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. The member letter will include:

- The impending termination of their provider
- Their right to request continued access to care
- The phone number to make PCP changes and/or forward referrals to Case Management for continued access to care consideration.

Members under the specialist care may also submit requests for continued access to care, including continued care after the transition period. Members should contact Anthem HealthKeepers Plus Member Services at **800-901-0020** (TTY **711**).

Newly Enrolled

The goal is to ensure the healthcare of newly enrolled members is not disrupted or interrupted. HealthKeepers, Inc. ensures continuity of care for newly enrolled members when:

- The member's health or behavioral health condition has been treated during an already existing provider-patient relationship with the provider

All new enrollees receive Evidence of Coverage (EOC) membership information in their enrollment packets. This also 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, the member is expected to notify DSS and their social worker. HealthKeepers, Inc. will continue to provide services until DMAS removes the member from the monthly enrollment file.

Services Not Available Within Network
HealthKeepers, Inc. will provide members with timely and adequate access to out-of-network services for as long as those services are necessary and not available within the network. However, HealthKeepers, Inc. is not obligated to provide members with access to out-of-network services if such services become available from a network provider.

When a provider refers a member for additional treatment or services, the referring provider must forward their NPI to the specialist.

The referring PCP and the specialist should follow these steps:

1. The PCP faxes the form to the specialist to ensure that the specialist has the PCP's NPI.
   - If the referring PCP's NPI number is not provided, the specialist will be responsible for contacting the PCP's office to obtain it.
2. The PCP lets the member know whether the provider they are being referred to is in-network or out-of-network.

Referrals are valid for as long as the member is under the care of the specialist.

Second Opinions

HealthKeepers, Inc. will help ensure that members have access to a second opinion regarding any medically necessary covered service. Members will be allowed access to a second opinion from a network provider, or, if a network provider is not available, from an out-of-network provider. This service is provided at no cost to the member. HealthKeepers, Inc. may require an authorization to receive specialty care for an appropriate provider.

Transportation

Emergency Transportation
HealthKeepers, Inc. 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, HealthKeepers, Inc. will provide emergency transport by ambulance.

Examples of conditions considered for emergency transport include, but are not limited to:

- Acute and severe illnesses/injuries
- Extensive burns
- Loss of consciousness
- Semi-consciousness, having a seizure or receiving cardiopulmonary resuscitation (CPR) treatment during transport
- Untreated fractures

Emergency transportation is also available for facility-to-facility transfers when the required emergency treatment is not available at the first facility.

Participating providers should be used, unless the provider has obtained a written acknowledgement (for example, a written waiver form) from the member prior to the service being rendered.

Nonemergency Transportation

Nonemergency transportation is a covered service for Cardinal Care members. Examples of circumstances considered include:

- Routine visits
- Same day/urgent visits
- From the ER
- To/from the pharmacy
- To/from the nursing home
- Trips for all covered benefits, including dental appointments
- Twenty-four Non-Medical trips a year to Grocery Store, Food Banks and Farmer Markets (limit of 30 mines with city/urban areas and 60 miles in rural areas)

The type of transportation available to Anthem HealthKeepers Plus members will depend on the member's location and condition (there are no exclusions for Cardinal Care members), but may include:

- Public transit
- Volunteer driver
- Gas reimbursement
- Car, van or taxi
- Wheelchair
- Stretcher van (including nonemergent ambulance)

Members must schedule an appointment with the transportation vendor within two business days at **8778923988** for the Anthem HealthKeepers Plus plan. Providers can also call to schedule a transportation appointment on behalf of a member.

FAMIS does not cover routine nonemergent transportation services but does cover nonemergent basic-life support and advanced-life support trips. Ambulance services will be covered if the member's condition suddenly becomes worse and must go to a local hospital's emergency room. FAMIS members are eligible for twenty four non-medical trips to Grocery Store, Food Banks and Farmer Markets.

For coverage of ambulance services, the trip to the facility or office must be to the nearest one recognized by the HealthKeepers, Inc., as having services adequate to treat the member's condition; the services received in that facility or provider’s office must be covered service. If requested by HealthKeepers, Inc. or DMAS, the attending provider must provide an explanation of why the member could not have been transported in a private car or by any other less expensive means.

Transportation services are not provided for routine access to and from providers of covered medical services. Professional ambulance services when medically necessary are covered when used locally or from a covered facility or provider office. This includes ambulance services for transportation between local hospitals when medically necessary; if prearranged by the Primary Care Physician and authorized by the HealthKeepers, Inc., if, because of the member's medical condition, the member cannot ride safely in a car when going to the provider's office or to the outpatient department of the hospital.

Emergency transportation that is medically necessary is covered (see the **Emergency Transportation** section above).

CHAPTER 16: PROVIDER ROLES AND RESPONSIBILITIES

Overview

HealthKeepers, Inc.'s goal is to provide quality healthcare at the right time, in the appropriate setting. To achieve this goal, PCPs, specialists and ancillary providers must fulfill their roles and responsibilities with the highest integrity. HealthKeepers, Inc. leans on providers' extensive healthcare education, experience, and dedication to their patients who, in turn, look to them to get well and stay well.

Primary Care Providers Roles and Responsibilities

PCPs are members' principle point of contact. Their role is to provide members with a medical home – their first stop in the healthcare process and a centralized hub for a wide variety of ongoing healthcare needs. HealthKeepers, Inc. furnishes each PCP with a current list of enrolled members assigned to them.

The PCP's role includes:

- Pulling their member panel roster from **https://Availity.com**
- Coordinating members' healthcare 24 hours a day, 7 days a week
- Integrating physical and behavioral health care for their patients
- Developing the member's care and treatment plan, including preventive care
- Maintaining the member's current medical record, including documentation of all services provided
- Adhering to the wait times outlined within the provider contract and provider manual
- Referring members for specialty care
- Coordinating with physical and behavioral services
- Providing complete information about proposed treatments and prognosis for recovery
- Facilitating interpreter services by presenting information in a language that members or their representatives can understand
- Ensuring that members' medical and personal information is kept confidential, as required by state and federal laws

Providers are encouraged to engage and direct development and provide feedback on members' care plans.

Members who would benefit from case management/care coordination services but either actively choose not to participate or are unable to participate may be managed through a provider-focused program.

PCPs are responsible for providing or arranging for:

- Routine and preventive healthcare services

- Emergency care services
- Hospital services
- Ancillary services
- Specialty referrals
- Interpreter services
- Coordination with outpatient clinical services, such as therapeutic, rehabilitative or palliative services

Note: Services should always be provided without regard to race, religion, gender, gender identity, color, national origin, age or physical/behavioral health status.

Members may select a PCP when they enroll with HealthKeepers, Inc. However, if a member does not select a PCP prior to the mailing of the member ID card, a PCP will be selected for the member. The member can change PCPs at any time.

HealthKeepers, Inc. keeps PCPs up to date with detailed member information by furnishing current lists of assigned members and, from time to time, providing medical information about members' potential healthcare needs. That way, providers can more effectively provide care and coordinate services.

PCPs and Assigned Members
Providers can confirm Cardinal Care members' PCP assignment by:

- Calling Anthem HealthKeepers Plus Provider Services at **800-901-0020** and:
  - Using the interactive voice response (IVR) system to verify PCP assignment
  - Speaking to a Provider Services representative
- Logging in to **https://Availity.com** to see monthly PCP rosters.

Nonparticipating providers need to obtain authorization before providing any nonemergency services to members.

Referrals
PCPs coordinate and refer patients to specialists, ancillary providers and community services. Providers should refer members to network facilities and providers. When this is not possible, providers should follow the appropriate process for requesting out-of-network referrals.

Note: Specialty referrals to network providers do not require prior authorization.

All PCPs:

- Are expected to help members schedule appointments with other healthcare providers, including specialists.

- Are expected to track and document appointments, clinical findings, treatment plans and care received by members referred to specialists or other healthcare providers, to ensure continuity of care.
- Are expected to refer members to health education programs and community resource agencies when appropriate.
- Must coordinate with the Woman, Infants and Children (WIC) program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin.
- Coordinate with the local tuberculosis (TB) control program to ensure that all members with confirmed or suspected TB have a contact investigation and receive therapy.
- Report to the DMAS or the local TB control program any member who is noncompliant, drug-resistant or who is or may be posing a public health threat.
- Are responsible for screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.

Out-Of-Network Referrals
HealthKeepers, Inc. recognizes there may be instances when an out-of-network referral is justified. The Care Management team will work with the PCP to determine medical necessity; after that, out-of-network referrals will be authorized on a limited basis.

Initial Health Assessment
PCPs should review their monthly eligibility list provided by HealthKeepers, Inc. and proactively contact their Anthem HealthKeepers Plus and FAMIS assigned members to make an appointment for an initial health assessment (IHA). These appointments should occur within the following time frames:
- Newborns: within 14 days of enrollment
- Children: within 60 days of enrollment
- Adults (18-21): within eight weeks of enrollment

The PCP's office is responsible for making and documenting all attempts to contact assigned members. Members' medical records must reflect the reason for any delays in performing the IHA, including any refusals by the members to have the exam.

Transitioning Members between Facilities or Back Home
PCPs initiate or help with the discharge or transfer of:
- Members at an inpatient facility to:
- The appropriate level-of-care facility (including skilled nursing or rehabilitation facilities) when medically indicated
- Their home
- Members who are hospitalized in an out-of-network facility to:
- An in-network facility

- Their home, with home health care assistance within benefit limits, when medically indicated

The coordination of member transfers from noncontracted, out-of-network facilities to contracted, in-network facilities is a priority that may require the immediate attention of the PCP. Contact the Utilization Management department to assist in this process at **800-901-0020**.

Interpreter Services

Providers must notify members of the availability of interpreter services and strongly discourage the use of friends and family members, especially children, acting as interpreters. Multilingual staff should self-assess their non-English language skills prior to interpreting on the job. Providers can find the current recommended employee language skills self-assessment tool in the ***Cultural Competency Toolkit*** at **https://providers.anthem.com/va** > **Training Academy** > Cultural competency and patient engagement.

For those instances when a provider cannot communicate with a member due to language barriers, interpreter services are available at no cost to the provider or member. Telehealth and voice-only interpreters for members needing language assistance, including American Sign Language, are available by placing a request up to one month in advance and no less than five days before a routine visit or 24 hours prior to rendering acute care services. A 48-hour cancellation notice is required when canceling sign language or Japanese interpreter services, and a 24-hour cancellation notice is required for all other requests. For all cancellations, advise members to also contact the physician to cancel the appointment.

HealthKeepers, Inc. no longer offers in-person/face-to-face interpretation services and will only offer telehealth and voice interpretation services, unless, at HealthKeepers, Inc.'s sole discretion, a special situation or circumstance requires in-person interpretation services. For cases that members and/or providers believe in-person interpretation services are necessary, such as for members needing American Sign Language assistance or members or parents/guardians needing assistance with reviewing and completing required provider documentation, the members or providers must receive prior authorization approval by HealthKeepers, Inc. If there is a unique situation that requires face-to-face interpretation, members or providers may contact our Customer Service teams using the number below to submit the authorization request.

To request interpreter services, Anthem HealthKeepers Plus providers and members should call **800-901-0020**.

Specialists

Specialists are licensed with additional training and expertise in a specific field of medicine. They supplement the care given by PCPs and are charged with the same responsibilities. That includes the responsibility for ensuring that necessary prior authorization has been obtained before providing services.

Access to specialty care begins in the PCP's office; the PCP will refer a member to a specialist for medically necessary services beyond the PCP's scope of practice. For urgent care, the specialist should see the member within 24 hours of receiving the request. For routine care, the specialist should see the member within two weeks of receiving the request.

A member may self-refer to a specialist without PCP referral. These cases include, but are not limited to:

- Chiropractic services (for FAMIS members only)
- Diabetes self-management
- Emergency services
- Family-planning services
- Immunizations
- Outpatient behavioral health services (in-network only, if not provided by a psychiatrist)
- Psychiatric services
- Podiatric services
- Routine vision services

Note: PCP referral and authorization are needed for out-of-network services or visits.

For some medical conditions, it makes sense for the specialist to be the PCP. Members may request that the specialist be assigned as the PCP if:

- The member has a chronic illness.
- The member has a disabling condition.
- The member is a child with special health care needs.

Behavioral Health Providers

For information about Behavioral Health providers, including transition after acute psychiatric care, see the **Behavioral Health Services** chapter.

Hospital Scope of Responsibilities

Hospital care is limited to plan benefits. PCPs refer members to contracted network hospitals for medically necessary services beyond the PCP's scope of practice. Hospital responsibilities include:

Notification of Admission and Services
The hospital must notify either HealthKeepers, Inc. or the review organization at the time the member is admitted, or the service is rendered. If the member is admitted or a service is rendered on a day other than a business day, the hospital must notify HealthKeepers, Inc. of the admission or service the morning of the next business day.

Notification of Admission Review Decision
If the hospital has not received notice of admission review determination at the time of a scheduled admission or service as required by the utilization management guidelines and the hospital agreement, the hospital should contact HealthKeepers, Inc. and request the status of the decision.

Any admission or service that has not received the appropriate review may be subject to post-service review denial. Generally, the provider is required to perform all admission review functions with HealthKeepers, Inc.; however, the hospital may ensure, before services are rendered, that such has been performed, or risk post-service denial.

Ancillary Scope of Responsibilities

Ancillary care is limited to plan benefits. PCPs and specialists refer members to in-network ancillary professionals for medically necessary services beyond the PCP's or specialist's scope of practice.

HealthKeepers, Inc. has a wide network of participating healthcare professionals and facilities. All services for which the healthcare professional is responsible are listed in the ancillary agreement.

Responsibilities Applicable to All Providers

Responsibilities applicable to all Anthem HealthKeepers Plus providers include:

- Adhering to office hours standards, including after-hours services
- Assisting disenrollees
- Verifying eligibility
- Collaboration
- Confidentiality
- Ensuring continuity of care
- Obtaining and maintaining licenses and certifications
- Mandatory reporting of abuse
- Maintaining medical records standards and documentation
- Maintaining an open clinical dialogue/affirmative statement
- Overseeing nonphysician practitioners
- Completing pre-service reviews
- Avoiding prohibited activities
- Adhering to policies regarding contract terminations

- Terminating the ancillary provider/patient relationship
- Updating provider information

The following sections outline these responsibilities in more detail.

Office Hours and After-Hours Services
To maintain continuity of care, office hours must be clearly posted, and members must be informed of the provider's availability at each site. There are guidelines for providing access to healthcare 24 hours a day, 7 days a week:

- Providers must be available 24 hours a day by telephone.
- During those times when a provider is not available, an on-call provider must be available to take calls.

After-hours Services: All PCPs must have an after-hours system in place to ensure members can call with medical concerns or questions after normal office hours. The answering service or after-hours personnel must forward member calls directly to the PCP or on-call physician or instruct the member that the provider will contact him or her within 30 minutes.

The answering service or after-hours personnel must ask the member if the call is an emergency. In the event of an emergency, the member must be immediately directed to dial 911 or to proceed directly to the nearest hospital emergency room.

If the PCP's staff or answering service is not immediately available, an answering machine may be used. The answering machine message must instruct members with emergency healthcare needs to dial 911 or go directly to the nearest hospital emergency room. The message must also give members an alternative contact number to reach the PCP or on-call provider with medical concerns or questions.

On-Call Providers: HealthKeepers, Inc. prefers that PCPs use network providers for on-call services. When that is not possible, the PCP must ensure the covering on-call physician or other professional provider abides by the terms of the provider contract. HealthKeepers, Inc. will monitor PCP compliance with after-hours access standards on a regular basis. Failure to comply may result in corrective action.

Members can also call the 24/7 NurseLine 24 hours a day, 7 days a week, to speak to a registered nurse. These nurses provide health information regarding illness and options for accessing care, including emergency services. The Anthem HealthKeepers Plus 24/7 NurseLine can be reached at **800-901-0020 (TTY 711)**.

Language-appropriate Messages: Non-English-speaking members who call their PCP after hours should expect to get language appropriate messages. In the event of an emergency, these messages should direct the member to dial 911 or proceed directly to

the nearest hospital emergency room. In a nonemergency situation, members should receive instruction on how to contact the on-call provider. If an answering service is used, personnel should know where to contact a telephone interpreter for the member. All calls taken by an answering service must be returned.

Disenrollees
When a member disenrolls and requests a transfer to another health plan, providers are required to work with case managers/care coordinators to help the member make the transition. This transition must occur without disruption of any regimen of care that qualifies as a continuity of care condition. The case manager/care coordinator will coordinate with the member, the member's providers and the case manager/care coordinator at the new health plan to help ensure an orderly transition.

Eligibility Verification
All providers must verify member eligibility through Availity Essentials, by calling DMAS, through the **MES portal** or by calling Provider Services before providing services, supplies or equipment. Eligibility may change monthly, so a member eligible on the last day of the month may not be eligible on the first of the following month. HealthKeepers, Inc. is not responsible for charges incurred by ineligible persons.

Collaboration
Providers share the responsibility of giving respectful care and working collaboratively with Anthem HealthKeepers Plus specialists, hospitals, ancillary providers, members and members' families. Providers must permit members to participate actively in decisions regarding medical care, including their decision to refuse treatment (except as limited by law). The provider also facilitates interpreter services and provides information about the EPSDT program.

Continuity of Care for Anthem HealthKeepers Plus and FAMIS Members
The PCP is responsible for providing an ongoing source of primary care appropriate to the member's needs, and maintains frequent communication with specialists, hospitals and ancillary providers to ensure continuity of care. HealthKeepers, Inc. encourages providers to maintain open communication with their patients regarding appropriate treatment alternatives, regardless of their benefit coverage limitations. HealthKeepers, Inc. has established comprehensive mechanisms to ensure continued access to care for members when providers leave the health plan. Unless otherwise indicated by DMAS or your Provider Agreement, all providers must provide a minimum of 30 days of continuity of care treatment to appropriately transition members if a member's situation warrants a transition. Under certain circumstances, members may finish a course of treatment with the terminating provider. Refer to your Provider Agreement for more details about continuity of care. For more information, refer to the **Access Standards** chapter.

Licenses and Certifications
Providers must maintain all licenses, certifications, permits, accreditations or other prerequisites required by HealthKeepers, Inc. and federal, state and local laws to provide medical services.

Mandatory Reporting of Child Abuse, Elder Abuse or Domestic Violence
Providers must ensure their office staff knows local reporting requirements and procedures to make verbal and written reports of known or suspected cases of abuse. All healthcare professionals must immediately report actual or suspected child abuse and neglect, elder abuse, domestic violence, physical abuse and sexual abuse 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 as required by law.

Medical Records Standards
Medical records must be maintained in a manner that ensures effective and confidential member care and quality review. HealthKeepers, Inc. performs medical record reviews upon signing a provider contract and, at a minimum, every three years thereafter to ensure providers are in compliance with these standards.

Medical records must be stored and retrieved in a manner that protects patient information according to the Confidentiality of Medical Information Act and must be retained for 10 years, per the Provider Agreement. This act prohibits a provider from disclosing any individually identifiable information regarding a patient's medical history, treatment or behavioral and physical condition without the patient's, legal representative, or specific legal authority's consent.

Records required through a legal instrument may be released without the patient's or patient representative's consent. Providers must be familiar with the security requirements of HIPAA and be in compliance.

For more information on medical records standards, please refer to the **Access Standards** chapter.

Open Clinical Dialogue/Affirmative Statement
Nothing within the provider agreement or provider manual should be construed as encouraging providers to restrict medically necessary covered services or limit the clinical dialogue between providers and their patients, regardless of benefit coverage limitations. Providers may communicate freely with members regarding:

- Treatment options available to them, including medication treatment options.
- Information the member needs to decide among all relevant treatment options.
- The risks, benefits and consequences of treatment or nontreatment.

- Members' right to participate in decisions regarding their healthcare, including the right to refuse treatment and to express preferences about future treatment decisions.

Oversight of Nonphysician Practitioners
All providers using nonphysician practitioners must provide supervision and oversight consistent with state and federal laws. The supervising physician and the nonphysician practitioner must have written guidelines for adequate supervision and all supervising providers must follow state licensing and certification requirements.

Nonphysician practitioners include:
- Advanced registered nurse practitioners
- Certified nurse midwives (if not directly contracted with HealthKeepers, Inc.)
- Physician assistants

Prohibited Activities
All providers are prohibited from:
- Billing eligible members for covered services.
- Billing members for noncovered services without a waiver that meets federal standards.
- Segregating members in any way from other persons receiving similar services, supplies or equipment.
- Discriminating against Anthem HealthKeepers Plus members or Medicaid participants.

Contracted providers provide services to the members in the same manner they provide those services to all non-Medicaid and non-FAMIS members, including those with limited English proficiency or physical or mental disabilities.

Provider Contract Termination
Unless otherwise outlined in the benefit plan or regulatory requirements, when a provider terminates their agreement, he or she must continue to provide covered services to members receiving treatment at the time of termination. Treatment continues until the earlier of 90 days or such time that: 1) the member has completed the course of treatment and, if applicable, was discharged or 2) reasonable and medically appropriate arrangements have been made for a participating provider to render covered services to the member.

Providers also agree to accept reimbursement from HealthKeepers, Inc. for all covered services furnished at the rates set forth in the Provider Compensation Schedule and adhere to HealthKeepers, Inc.'s policies, including but not limited to those regarding quality assurance requirements, referrals, preauthorization and treatment planning.

For members who have entered the pregnancy at the time of termination, treatment continues through the postpartum care directly related to their delivery. For members who are defined as terminally ill under § 1861 (dd) (3) (A) of the Social Security Act, treatment continues for the remainder of their life for care directly related to the treatment of the terminal illness.
HealthKeepers, Inc. notifies members impacted by a termination upon receiving a provider's notice to terminate a contract. The written notification informs affected members of:

- The impending termination of their provider.
- Their right to request continued access to care.
- The Member Services phone number to make PCP changes.
- Referrals to UM for continued access to care consideration.

Members under a specialist's care can also submit requests for continued access to care, including continued care after the transition period, by calling Anthem HealthKeepers Plus Provider Services at **800-901-0020**.

Per the Provider Agreement, HealthKeepers, Inc. can terminate any Provider Agreement without cause. Moreover, if HealthKeepers, Inc. determines that the quality of care or services provided by a healthcare professional is not satisfactory (as evidenced by member satisfaction surveys, member complaints or grievances, utilization management data, complaints or lawsuits alleging professional negligence or any other quality of care indicators), HealthKeepers, Inc. may terminate the provider agreement.

Termination of the Ancillary Provider/Patient Relationship
Under certain circumstances, an ancillary provider may terminate the professional relationship with a member in accordance with the provisions in this manual. Ancillary providers may not terminate the relationship because of the member's medical condition, or the amount, type or cost of covered services required by the member.

Updating Provider Information
Providers are required to inform HealthKeepers, Inc. of any material changes to their practice such as:

- Professional business ownership
- Business address/the location where services are provided
- Federal nine-digit TIN
- Specialty
- Adding new or removing practitioners to the group
- Availability of services for children
- Languages spoken

- Demographic data (for example, phone numbers, languages of providers and/or office personnel)
- Legal or governmental action initiated against a healthcare professional.
- This includes, but is not limited to, an action for professional negligence, violation of the law, or against any license or accreditation which, if successful, would impair the ability of the healthcare professional to carry out the duties and obligations under the provider agreement.
- Other problems or situations that may impair the ability of the healthcare professional to carry out the duties and obligations under the provider agreement care review and grievance resolution procedures
- Open panel status
- Selling or transferring control to any third party
- Acquiring other medical practice or entity
- Change in accreditation
- Change in affiliation
- Change in licensure or eligibility status, or
- Change in operations, business or corporation

42 C.F.R. § 438.10(h)(l)(i)-(viii) requires HealthKeepers, Inc. to include additional information about provider practices in our provider directories for members. If you have not already provided us with information about your practice website/URL, accommodations for people with physical disabilities (such as wide entry, wheelchair access, accessible exam room(s) and tables, lifts, scales, bathrooms and stalls, grab bars, or other accessible equipment), and whether you have completed cultural competency training, please provide that information to us.

Facility and ancillary providers submit changes on company letterhead to their Anthem HealthKeepers Plus Provider Relations representative. To comply with the Federal 21st Century Cures Act, providers must also update their demographic data with DMAS using the PRSS module. For more information, visit the DMAS website at **https://www.dmas.virginia.gov/for-providers/medicaid-enterprise-system/**.

Exclusion for Participation in Federal Healthcare Programs

Overview

The Office of Inspector General (OIG) of U.S. Department of Health and Human Services has the authority to exclude certain individuals and entities from participating in federal healthcare programs. The effect of an OIG exclusion from federal healthcare programs is that no federal healthcare program payment, including any payments from HealthKeepers, Inc. on behalf of any Medicaid member, may be made for any items or services (1) furnished by an excluded individual or entity, or (2) directed or prescribed by an excluded physician (42 CFR 1001.1901). Any items and services furnished by an

excluded individual or entity are not reimbursable. In addition, any items and services furnished at the medical direction or prescription of an excluded physician are not reimbursable when the individual or entity furnishing the services either knows or should know of the exclusion. This prohibition applies even when the federal payment itself is made to another provider, practitioner or supplier that is not excluded.

Requirements

- Providers and entities are required to check the OIG List of Excluded Individuals/Entities on the OIG website (**https://exclusions.oig.hhs.gov**) prior to hiring or contracting with individuals or entities.
- Healthcare providers and entities are required to periodically check the OIG website for determining the participation/exclusion status of current employees and contractors. The website contains OIG program exclusion information and is updated on a regular basis.
- Providers and entities are required to inform HealthKeepers, Inc. immediately if they, any of their staff, or their legal entity are excluded from participating in federal healthcare programs including Medicare and Medicaid.

Disclosure of Ownership and Control Interest Requirements

Overview

Federal regulation requires disclosure of the information requested in the Disclosure of Ownership and Control Interest Statement Form (DOO). The DOO is applicable to all providers (individuals, facilities and ancillary providers) that participate in state-based healthcare programs, including Medicaid.

Requirements

- Providers are required to disclose the information requested on the form prior to participation in the network.
- The individual completing the form must be the provider, managing employee or an individual with the authority to legally bind the entity.
- If the information provided in the DOO changes, providers are required to send HealthKeepers, Inc. updated information within 35 days.
- Every three years after submission of the original DOO, an updated DOO must be submitted by all providers.
- A DOO must be completed legibly, to include date of birth (DOB) and Social Security numbers (SSN) when requested.
- Sections that do not pertain to a provider/entity must be marked as “N/A.”
- The DOO should be submitted to a provider’s network manager.

The **DOO** can be found and printed for resubmission at **https://providers.anthem.com/va** > **Forms > Other Forms** Providers can also contact their network manager to obtain a copy.

A network manager listing can be found by visiting **https://www.anthem.com/provider/getting-started**.

Please note that network managers are specific to provider type and region. If a DOO is requested due to form errors, form incompleteness or lack of submission or renewal, submit the form as requested in that correspondence.

Please follow these guidelines for signatures:

- **Providers:** Only the person disclosing information can sign the form; signature stamps are not acceptable.
- **Disclosing entities**: The signature must be that of an individual with the power to legally bind the entity, such as an owner or officer.
- **Managing employee or administrator**: The signature of a managing employee or administrator is acceptable, but it is required that these individuals provide their SSN and DOB as well.

Completing the Form

- Providers must answer every question on the DOO.
- If providers answer yes to any question, they must include additional information in the corresponding fields. Missing information can result in a delay in processing and will require resubmission.
- Every applicable field must be completed in the “Provider Information” section.
- Questions related to the Council for Affordable Quality Healthcare (CAQH) number are only applicable to providers that disclose themselves as an individual practitioner; groups and disclosing entities are not required to provide this information. If needed, providers can obtain their CAQH number by calling **888-599-1771** or visiting **www.caqh.org/solutions/caqh-proview**.
- “Section I” must **always** be completed. Individual providers must provide their address, DOB and SSN. Provider entities may provide the TIN and business address. Each individual with direct or indirect ownership of 5% or more or has a controlling interest must be listed.
- Providers may attach additional attachments to the DOO if needed. Accepted formats include Word documents, Excel spreadsheets and portable document format (PDF) documents.

Providers may contact Anthem HealthKeepers Plus Provider Services at **800-901-0020** with any questions.

Provider Rights

Anthem HealthKeepers Plus providers, acting within the lawful scope of practice, are not prohibited from advising a member or advocating on behalf of a member for any of the following:

- The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered
- Any information the member needs in order to decide among all relevant treatment options
- The risks, benefits and consequences of treatment or nontreatment
- The member's right to participate in decisions regarding their healthcare, including the right to refuse treatment and to express preferences about future treatment decisions
- The grievance and appeals process and state fair hearing procedures
- Access to policies and procedures covering authorization of services
- Notification of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested
- To challenge, on behalf of members, the denial of coverage, or payment for, medical assistance
- To be free from discrimination for the participation, reimbursement or indemnification of any provider who is acting within the scope of his/her license or certification under applicable law

Anthem HealthKeepers Plus provider selection policies and procedures do not discriminate against particular providers who serve high-risk populations or specialize in conditions that require costly treatment.

Professional and Respectful Communication Standards

HealthKeepers, Inc. maintains an ongoing commitment to fostering a respectful, collaborative, and professional environment, recognizing that effective communication is an integral component. Your Participating Provider Agreement (the "Agreement") with HealthKeepers, Inc. outlines your obligations as a participating provider with HealthKeepers, Inc. regarding conduct and professionalism. Providers, including those who represent them, such as office staff, billing entities, etc., are expected to conduct themselves in a professional and respectful manner in all interactions with Anthem HealthKeepers Plus members, employees, and representatives. Professional and respectful communication is not just a courtesy, but a fundamental responsibility that supports collaboration, builds trust, and enhances the quality of service we offer to our members. By upholding these standards, Providers contribute to a positive and inclusive atmosphere where every individual feels valued and respected.

In addition to the standard policies and guidelines outlined in this manual and your participating Provider Agreement, HealthKeepers, Inc. maintains a zero-tolerance policy

for abusive or disruptive behavior, whether physical or verbal, from Providers, or those representing Providers, during the course of business. Violent acts and/or continued abusive or disruptive behavior will result in the termination of your participation in the Anthem HealthKeepers Plus provider network.

Examples of behavior that will not be tolerated include, but are not limited to, any act of violence, threats, harassment, intimidation, and other disruptive behavior. Such behavior can include actual physical injury, direct or indirect verbal or written statements, disruptive behavior, suggestions of self-harm, threats of retaliation to others, or gestures that communicate a threat of physical harm.

Restrictions on AI use in Performing a Health Plan Function

Providers who have been delegated to perform a health plan function (e.g., Utilization Management, credentialing and/or claims payment) shall not use AI in the performance of any delegated health plan function without the advance written consent of the health plan. Providers shall request such approval in accordance with the notice provisions of the provider agreement and the health plan shall provide its' written response in accordance with the notice provisions of the provider agreement.

CHAPTER 17: CLINICAL PRACTICE AND PREVENTIVE HEALTHCARE GUIDELINES

Overview

HealthKeepers, Inc. believes that providing quality healthcare should not be limited to the treatment of injury or illness and is committed to helping providers and members become more proactive in the quest for better overall health.

To accomplish that goal, HealthKeepers, Inc. offers providers tools to help find the best, most cost-effective ways to:

- Provide member treatment
- Empower members through education
- Encourage member lifestyle changes where possible

HealthKeepers, Inc. wants providers to have access to the most up-to-date clinical practice and preventive healthcare guidelines. These guidelines, offered by nationally recognized healthcare organizations and based on extensive research, include the latest standards for treating the most common, stubborn and serious illnesses, such as diabetes and hypertension. They also include guidelines for preventive screenings, immunizations and member counseling, based on age and gender.

Clinical Practice Guidelines

HealthKeepers, Inc. considers Clinical Practice Guidelines (CPGs) an important component of healthcare. HealthKeepers, Inc. has adopted nationally recognized CPGs and encourages physicians to utilize these guidelines to improve members' health.

Several national organizations produce guidelines for asthma, diabetes, hypertension and other conditions. The guidelines, which are used for quality and condition care programs, are based on reasonable medical evidence. HealthKeepers, Inc. reviews the guidelines at least every two years, or when changes are made, for content accuracy, current primary sources, new technological advances and recent medical research.

Providers can access the CPGs on the provider website at **https://providers.anthem.com/va**.

The website offers the most up-to-date clinical resources and guidelines. Providers may also request a hard copy of the CPGs by calling Anthem HealthKeepers Plus Provider Services at **800-901-0020**.

CHAPTER 18: CARE MANAGEMENT/CARE COORDINATION

Overview

Care management/care coordination emphasizes collaborative, multidisciplinary teamwork to develop, implement, coordinate and monitor treatment plans that optimize members' healthcare benefits. The integration of physical and behavioral health is core to members' holistic care management.

Members may be identified as one of three priority population groups for assignment to care management (or care coordination, as appropriate): Mandatory High Priority, Mandatory Priority Populations and MCO Determined Priority.

- **Mandatory High Priority Populations:** Members identified as high priority will be assigned to High Intensity Care Management.
- **Mandatory Priority Populations:** HealthKeepers, Inc. will assign each member identified as a Mandatory Priority Population to either low, moderate, or high-intensity care management, depending on the member's needs and risk level.

In addition to the priority populations described above, other members are assigned to care management based on the range of information HealthKeepers, Inc. has on the individual and assessment of their need and risk. Care management level assignments may be temporary based on a member's changing needs and progress towards stability working with treating providers and living in the community.

HealthKeepers, Inc.'s innovative, member centric and provider focused approach assigns a healthcare management team led by regional, field-based physical and behavioral health care managers, social workers, member outreach specialists, nurse practice consultants and network relations representatives throughout Virginia. The team also includes departments and employees performing support activities for members and providers and assisting them in navigating the healthcare system. They are the primary points of contact for providers in their assigned region.

By establishing collaborative, supportive relationships with PCPs and community mental health centers, HealthKeepers, Inc. supports members' medical homes as the center of the care delivery system. This links providers, members and community agencies to resources and supports and assists providers in best serving Anthem HealthKeepers Plus members. HealthKeepers, Inc. is available to:

- Provide training for healthcare professionals and their staff regarding enrollment, covered benefits, managed care operations and linguistic services.
- Provide member support services, including health education referrals, event coordination and coordination of cultural and linguistic services.
- Provide care management services to supplement providers' treatment plans and improve members' overall health.

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- This is done by informing, educating and encouraging self-care in the prevention, early detection and treatment of existing conditions and chronic disease.
- Coordinate access to community health education resources such as breastfeeding, smoking cessation, diabetes and asthma.

The care management/care coordination program is provided at no cost to providers and members. The case manager/care coordinator, in partnership with providers and members, collects data and analyzes information about actual and potential care needs to develop a treatment plan. Cases referred to case management/care coordination may be identified by disease or condition, dollars spent or high utilization of services.

HealthKeepers, Inc. encourages providers to engage and direct development and provide feedback to members' care plans. Members who would benefit from case management/care coordination services but either choose not to participate or are unable to participate may be managed through a provider-focused program.

Providers who serve members engaged in care management shall participate in annual care conferences with an interdisciplinary care team. The goal is to coordinate services for members across the care continuum. Providers may bill for the semiannual conference using HCPCS code 99211 SC.

Care management/care coordination is sensitive to cultural diversity and the impact it has on members and their interaction within the healthcare system. HealthKeepers, Inc. encourages providers to become familiar with the cultural and linguistic training materials available on the provider website at **https://providers.anthem.com/va**. Interpreter services are available at no cost to support the care management/care coordination process.

Care Managers and the Care Management Team

The care manager's/care coordinator's role is to assess the member's healthcare status, develop a healthcare plan and:

- Facilitate communication and coordination within the healthcare team.
- Facilitate communication with the member and his or her family in the decision-making process.
- Educate the member and providers on the healthcare team about care management, community resources, benefits, cost factors and all related topics, so that informed decisions can be made.
- Encourage appropriate use of medical facilities and services, with the goal of improving quality of care and maintaining cost-effectiveness on a case-by-case basis.
- Assist PCPs with access to specialists, if needed.

The case manager/care coordinator periodically reassesses the care plan to monitor:

- Progress toward goals.
- Whether present care levels are adequate.
- Necessary revisions.
- New issues that need to be addressed.

The case management/care coordination team includes social workers, LPNs and experienced registered nurses, many of whom are certified case managers (CCM) The case manager/care coordinator social workers add valuable skills that allow HealthKeepers, Inc. to address not only members' medical needs, but also their psychological, social and financial issues.

HealthKeepers, Inc. offers several avenues for members to be identified or referred for case management/care coordination, including:

- Health information line
- Condition Care program
- Discharge planner (from hospital)
- Utilization Management
- Member or caregiver
- Practitioner

When a member has been identified as having a condition that may benefit from case management/care coordination, the care manager/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 case manager/care coordinator develops an individualized care plan. That plan may involve coordinating services with public and behavioral health departments, schools and other community health resources.

Anthem HealthKeepers Plus members or providers can request a level of care redetermination at any time to ensure the right level of care is being met. Once goals are met or case management/care coordination can no longer impact the case, the case manager/care coordinator closes the member's case.

How to get in contact with Care Management Team: Call 800-901-0020 option 6
Hours of Operation Monday to Friday from 8am -6pm

Provider Responsibilities

Providers have the responsibility to participate in the case management/care coordination process. They share information and facilitate the process by:

- Referring members who could benefit from case management/care coordination.

- Sharing information as soon as possible (and as early as the initial health assessment) if the PCP identifies complex healthcare needs.
- Collaborating with care management/care coordination staff on an ongoing basis.
- Participating in semiannual care conferences.
- Recommending referrals to specialists as required.
- Monitoring and updating the care plan to promote healthcare goals.
- Notifying case management/care coordination if members are referred to services provided by the state or some other institution not covered by the HealthKeepers, Inc. agreement.
- Coordinating county- or state-linked services such as public health, behavioral health, schools and waiver programs.

Members may be enrolled in the state's individualized education plan (IEP), which provides services to special needs students such as physical therapy, speech pathology, audiology, school nursing and rehabilitation counseling. Anthem HealthKeepers Plus providers are responsible for communicating and coordinating with the school to ensure continuity of care and avoid duplication of services.

Referrals

HealthKeepers, Inc. offers several avenues for members to be identified or referred for case management/care coordination:

- Health information
- Condition Care programs
- Discharge planning (from the hospital
- Utilization management
- Working with the member, caregiver and practitioners

Providers, nurses, social workers, members or member's representatives may also request care management/care coordination services. Examples of cases appropriate for referral include:

- Adults with special healthcare needs requiring coordination of care
- Auto-immune diseases such as HIV/AIDS
- Children with special healthcare needs
- Chronic illness such as asthma, diabetes and heart failure
- Complex or multiple-care needs such as multiple trauma or cancer
- Frequent hospitalizations or emergency room utilization
- Hemophilia, sickle cell anemia, cystic fibrosis, cerebral palsy
- Spinal injuries
- High-risk pregnancies
- Potential transplants
- Pre-term births

- Medically frail
- Member on home- and community-based services waiver waitlist
- Foster children

To refer Anthem HealthKeepers Plus members to case management, call **800-901-0020** or fax **866-920-4097. Hours of operation are 8 a.m. to 6 p.m. Monday through Friday**.

Behavioral Health Case Management/Care Coordination

HealthKeepers, Inc. ensures the integration of physical and behavioral health care management. For information about behavioral health case management/care coordination, clinical authorization and protocols, see the **Behavioral Health Services** chapter.

CHAPTER 19: QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

Overview

HealthKeepers, Inc. aims to continuously measure improvement in the delivery of, and access to, high-quality healthcare. Following regulatory and accrediting body requirements, HealthKeepers, Inc. has a Quality Assessment and Performance Improvement (QAPI) program to monitor and evaluate the quality, safety and appropriateness of medical and behavioral health care and service offered by the health network. The QAPI program also serves to identify and act on opportunities for improvement.

HealthKeepers, Inc. leadership is responsible for organizational governance and has final authority and accountability for the QAPI program. Leadership assigns responsibility for the development and implementation of the QAPI program to the Medicaid quality management committee (QMC). HealthKeepers, Inc. seeks external advisory guidance to provide input on internal programming. Service and operations committees also work together to coordinate clinical and service quality improvement activities. Quality management leadership has day-to-day oversight of the QAPI program. There are quality processes in place throughout the enterprise to maintain the connection with the local members, providers, and community.
The QMC reviews and approves the annual quality program documents, including the QAPI program description, QM work plan and the QAPI program's annual evaluation. The results of the annual QAPI evaluation are used to develop and prioritize the next year's annual QM work plan.

The QAPI program is collaborative in nature and includes focused studies and reviews that measure quality of care in specific clinical and service areas. Providers are expected to participate to help achieve the goal of providing responsive, safe and cost-effective healthcare that makes a difference in members' lives.

Program Monitoring

To enable comprehensive assessment of the plan's health system and meaningful prioritization of initiatives, HealthKeepers, Inc. selects critical monitors from the QAPI program components:

- Accessibility of services
- Availability of practitioners
- Behavioral health
- CAHPS® member satisfaction survey
  CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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- Preventive health guidelines
- Clinical Practice Guidelines for medical and behavioral health
- Complaints, grievances and appeals
- Continuity/coordination of care
- Contracting
- Facility site review
- HEDIS
- Health equities and cultural and linguistic services
- Health services programs
- Maternity management
- Medical record review
- Member, practitioner and provider communications
- Patient safety
- Pharmacy and therapeutics
- Provider credentialing/recredentialing
- Provider satisfaction
- Utilization and case management/care coordination
- Performance measurements

Internally, areas to monitor are selected by identifying aspects of care and/or service that are problem prone or high in volume or risk. Selections are based on the probability that the review will have a positive impact on the member's health and well-being. Priority is given to those areas with issues related to major population groups, the member's health risks, and where actions are likely to have the greatest member impact.

Externally, states may require certain clinical measures to achieve a specific benchmark or will provide incentives/performance guarantees for individual measures. In addition, CMS, in conjunction with the Commonwealth of Virginia, may specify performance measures and topics for performance improvement projects (PIPs) and require mechanisms to detect both underutilization and overutilization of services. Ongoing PIPs are typical and include:

- Measuring performance using objective quality indicators.
- Implementing interventions to achieve quality improvement.
- Evaluating the effectiveness of the interventions.
- Planning and initiating activities to increase or sustain improvement.

HEDIS measures and the requirements of the NCQA are also considered, whether clinically based or service related.

PIPs can be focused on either clinical or nonclinical services.

HealthKeepers, Inc. is committed to working collaboratively with network physicians and hospitals to identify preventable adverse events (PAE) as a means of improving the quality and safety of patient care.

Accreditation

HealthKeepers, Inc. maintains health plan accreditation through the NCQA. Accreditation is a process for an impartial organization to review a company's operations, to ensure it is conducting business consistent with national standards. Accreditation fulfills state regulatory requirements and, in some instances, serves as a substitute for meeting a state's quality requirements. It also supports continuous improvement, guiding the plan to measure, analyze, report and improve the quality of services provided to members.

Two of the most important measures of performance and member satisfaction are HEDIS and CAHPS. HEDIS is a set of standardized performance measures used to compare the performance of managed care plans and measures for physicians based on value rather than cost. More than 90% of America's health plans use the HEDIS tool and report rates annually. The CAHPS survey is a member satisfaction survey administered annually to a random sample of:

- Members who are under age 19 or pregnant.
- Members age 19-64 or who are low-income.
- Members who are aged, blind and disabled eligible (ABD) and non-dually eligible.

Plan scores are compared to other health plans' scores on specific measures for benchmarking purposes. Accreditation results are displayed on public websites to assist employers and individual consumers in making informed decisions about their health plan options, based on quality and value.

Quality Assessment and Performance Improvement Program

The Quality Assessment and Performance Improvement Program (QAPI) 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:

- Utilization management, condition care and maternity management programs
- Case management/care coordination of members with complex health conditions
- Behavioral health programs
- Clinical practice and preventive health guidelines
- Patient safety
- Coordination of medical and behavioral health care
- Access and availability of services and practitioners
- Facility site review

- Medical record review
- Pharmacy and therapeutics
- Provider/member satisfaction
- Service quality
- Health equities, and cultural and linguistic program
- Complaints, grievances and appeals

The QAPI program is defined within three quality documents that support program excellence:

- The **program description** describes the overall health plan approach to QM, goals and objectives, and how the QAPI Program will be managed and monitored by the organization.
- The **work plan** lists the various quality interventions and activities, and how the goals/objectives are tracked and monitored throughout the year through reports to the quality committees.
- The **evaluation** is the annual reporting method used to evaluate the progress and results of planned activities toward established goals. It describes the accomplishments of the QAPI program and QM work plan.

Each year, as part of the continuous quality improvement (CQM) process, HealthKeepers, Inc. reviews its QAPI program description to:

- Establish goals/objectives for its QM activities and implement a QM work plan to improve the level of care and service provided to its members.
- Conduct a QAPI evaluation to assess the effectiveness of the activities implemented throughout the year and determines if the goals and objectives were met.

QAPI Program revisions are made based on outcomes and trends, overall satisfaction with the effectiveness of the program, and contractual, accreditation and regulatory standards and requirements.

Providers support the activities of the QAPI Program by:

- Completing corrective action plans, when applicable.
- Participating in the facility site review and medical record review processes.
- 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.
- Using preventive health and Clinical Practice Guidelines in member care.

Call Anthem HealthKeepers Plus Provider Services at **800-901-0020** for more information on the QAPI Program, its achievements, processes and outcomes.

Healthcare Effectiveness Data and Information Set

Practitioners and providers must allow HealthKeepers, Inc. to use performance data in cooperation with the QAPI Program and activities. Provider performance data refers to compliance rates, reports and other information related to the appropriateness, cost, efficiency and/or quality of care delivered by an individual healthcare practitioner (for example, a physician) or a health care organization (for example, a hospital).

Common examples of performance data include the HEDIS quality of care measures maintained by the NCQA and the comprehensive set of measures maintained by the National Quality Forum (NQF). Performance data may be used for multiple plan programs and initiatives.

HealthKeepers, Inc. is 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

The QM staff will contact the provider's office to review or copy any medical records required for quality improvement studies. Office staff must provide access to medical records for review and copying.

Overutilization and Underutilization

Overutilization and underutilization are reviewed annually utilizing HEDIS data. This analysis facilitates the delivery of appropriate care by monitoring the impact of UM programs as well as identifying and correcting potential overutilization and underutilization. HealthKeepers, Inc. utilizes the data to measure compliance with established goals and national averages or benchmarks where applicable.

Best Practice Methods

Best practice methods are an up-to-date compilation of effective strategies for quality healthcare delivery. HealthKeepers, Inc. shares its best practice methods with providers during provider site visits. Quality and Provider Relations teams educate providers on policies and procedures, with the help of 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
- Office practice optimizations

Member Satisfaction Surveys

HealthKeepers, Inc. conducts CAHPS member satisfaction surveys each year through a contracted vendor certified by the NCQA. The CAHPS survey includes rating measures of members' overall satisfaction with their health plan, all healthcare received, and their personal doctor and specialist(s). Other areas of assessment include ease of accessing care, quality of physician services, customer service and claims processing. The privately contracted survey allows HealthKeepers, Inc. to add additional questions to the survey to help better understand members' perceptions and enable the development of meaningful interventions.

CAHPS survey results are compared to the previous years' results and to the NCQA Quality Compass®. This is a database maintained by the NCQA that includes results from all CAHPS health plan surveys nationwide, including national averages and percentiles. Opportunities for improvement are identified and priorities are set based on the review and analysis of scores, as well as those areas where the plan can make the greatest impact. Recommendations for prioritizing the focus areas for improvement are reviewed with the appropriate quality committees and stakeholders.

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

HealthKeepers, Inc. reviews the results of the CAHPS survey with providers annually through an article in the Anthem HealthKeepers Plus newsletter. Providers are encouraged to review the results, share them with office staff, and address any areas of deficiency in their offices.
On an annual basis, member satisfaction is comprehensively analyzed by combining the results of CAHPS surveys with member complaints, grievances and appeals. Together, these important barometers of member satisfaction are considered when making plans for improving service and customer satisfaction.

Provider Satisfaction Surveys

HealthKeepers, Inc. may conduct provider surveys to monitor and measure provider satisfaction with Anthem HealthKeepers Plus services and identify areas for improvement. Participation in these surveys is highly encouraged; provider feedback is very important. HealthKeepers, Inc. informs providers of the results and plans for improvement through provider bulletins, newsletters, meetings or training sessions.

Medical Record Documentation Standards

Providers are required to maintain medical records in a manner that is current, organized, and permits effective and confidential member care and quality review. HealthKeepers, Inc. performs random medical record reviews of all PCPs (general

practice, family practice, internal medicine, pediatrics and select obstetrics/gynecology) to ensure that network providers are in compliance with these standards.

Network providers shall agree to maintain the confidentiality of member information and information contained in a member's medical records according to HIPAA standards. Medical records must be stored and retrieved in a manner that protects patient information according to the Confidentiality of Medical Information Act:

- The act prohibits a healthcare provider from disclosing any individually identifiable information regarding a patient's medical history, mental condition, physical condition or treatment without the member's, member's legal representative's or specific legal authority's consent.
- Note: Records required through a legal instrument may be released without patient or patient representative consent.
- Providers must be familiar with the HIPAA security requirements and will only release such information as permitted by applicable federal, state and local laws that is:
  - Necessary to other providers and the health plan related to treatment, payment or healthcare operations.
  - Upon the member's signed and written consent.

Security

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

Storage and Maintenance

Active medical records shall be secured and must be inaccessible to unauthorized persons. Medical records are to be maintained in a manner that is current, detailed and organized, and that permits 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. Per the Provider Agreement, records must be retained and maintained for 10 years.

Electronic record-keeping system procedures shall be in place to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures and maintain upkeep of computer systems. Security systems shall be in place to provide back-up storage and file recovery, to provide a mechanism to copy documents and to ensure that recorded input is unalterable.

Availability
The medical records system must allow for prompt retrieval of each record when the member comes in for a visit. 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. They must be maintained for at least seven years as required by state and federal regulations.

Providers must offer a copy of a member's medical record upon reasonable member request at no charge and facilitate the transfer of the member's medical record to another provider at the member's request. Confidentiality of, and access to, medical records must be provided in accordance with the standards mandated in HIPAA and all other state and federal requirements.

Providers must permit HealthKeepers, Inc. and representatives of DMAS 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. DMAS encourages providers to use technology, including health information exchanges, to transmit and store medical record data.

Minimum Requirements
Every medical record must, at a minimum, include:

- The patient's name or ID number on each page in the record.
- Personal biographical data including home address, employer, emergency contact name and telephone number, home and work telephone numbers, and marital status.
- All entries dated with month, day and year.
- All entries contain the author's identification (for example, handwritten signature, unique electronic identifier or initials) and title.
- Medical records must be legible, dated, and signed by the physician, physician assistant, nurse practitioner or nurse midwife providing patient care.
- Identification of all providers participating in the member's care, and information on services furnished by these providers.
- A problem list, including significant illnesses and medical 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 of NKA that the patient has no known allergies or history of adverse reactions).
- Information on advance directives.
- Past medical history, including serious accidents, operations, illnesses.
- For patients 14 years old and older, appropriate notations concerning the use of cigarettes, alcohol and substance use, including anticipatory guidance and health education.
- For children and adolescents, past medical history relates to prenatal care, birth, operation(s) and childhood illnesses.
- Physical examinations, treatment necessary and possible risk factors for the member relevant to the particular treatment.
- Prescribed medications, including dosages and dates of initial or refill prescriptions.
- Information on the individuals to be instructed in assisting the patient.
- An immunization record for children that is up-to-date, or an appropriate history for adults.
- Documentation attempts to provide immunizations.
- If the member refuses immunization, a signed statement by the member or guardian shall be documented in the member's medical record, as proof of voluntary refusal.
- Evidence of preventive screening and services, in accordance with preventive health practice guidelines.
- 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, of the provider's 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.
- Documentation on whether an interpreter was used, and, if so, that the interpreter was also used in follow-up.

No evidence that the patient is placed at inappropriate risk by a diagnostic test or therapeutic procedure should be found in the medical record.

Advance Directives
Recognizing a person's right to dignity and privacy, 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 may be asked to assist members in procuring and completing the necessary forms.

Advance directive documents should be on hand in the event a member requests this information. Any request should be properly noted in the medical record.

Medical Record and Facility Site Reviews

In support of the requirements in the provider manual to establish standards and thresholds for overall provider quality, including, at a minimum, office site criteria and medical/treatment record keeping practices, when a provider meets thresholds established herein, a site visit shall be conducted by the company. This policy applies to all providers.

The policy is to protect the health and safety of members by outlining a process for evaluating a provider office site, including but not limited to:

1. Receipt of a member grievance concerning physical accessibility, physical appearance, adequacy of waiting and examining room space, discrimination of any kind, rudeness of provider staff, and any other perceived unprofessional behavior by provider staff, and/or adequacy of medical/treatment records and/or record keeping practices
2. When the grievance received is determined to be a critical incident (for example, severe enough to potentially endanger or endangers member's health and well-being)
3. A sentinel event
4. When a pattern related to the quality of the site is identified
5. Any quality or quality-of-care issue or any concern or question that the company may have regarding the provider site

All providers are required to meet standards set forth by the company and comply with state and federal regulations.

Definitions

1. Company — HealthKeepers, Inc.
2. Critical incident — an event that may negatively impact the health, safety, or welfare of an individual
3. Provider — any entity that provides services to HealthKeepers, Inc. members
4. Grievance — an expression of dissatisfaction from a member or member representative about any matter other than an action. Possible subjects for grievances include but are not limited to the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights. A member, member's authorized representative or provider with a member's written consent may file a grievance.
5. Office site visit — on-site inspection of a provider's office, premises, operation, etc. by the company
6. Provider — any entity delivering or supplying services to a company member
7. Provider Office Site Evaluation Form — this form is utilized to score the office site quality measurements

8. Quality-of-care issue — a medical, social, environmental, or economical event that has the potential to have an adverse effect on the health and welfare of our internal and external customers, members, or the organization
9. Quality threshold — provider receiving three or more grievances within a six-month period related to the following components. The threshold is considered met if the grievances received are in one or more of the designated components:
    a. Physical accessibility
    b. Physical appearance
    c. Adequacy of waiting and examining room space
    d. Discrimination of any kind
    e. A critical incident
    f. A sentinel event
    g. When a pattern related to the quality of the site is identified, any quality or quality of care issue or any concern or question that the company may have regarding the provider site
    h. Rudeness of provider staff and any other perceived unprofessional behavior by provider staff, and/or adequacy of medical/treatment record keeping practices
10. Scoring — a minimum threshold of eighty percent or greater in each component is considered a passing audit score. The acceptable performance for on-site visits for each office location and medical record reviews for the applicant is, at a minimum, a passing score of 80% in each of the designated components outlined in number 10 above. Any exception to the minimum passing score is at the discretion of the company and must be based on compelling circumstances.
11. Sentinel event — an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase ‘or risk thereof’ includes any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Such events are called sentinel because they signal the need for immediate investigation and response.

Procedure

Office site quality regarding member grievances about providers’ offices

- Member grievances related to the quality of all provider sites and interactions with company members are monitored and investigated when received.
- Once the quality threshold is met, an on-site visit shall occur within 30 days to assess the office site quality. The visit may be scheduled with the provider, or it may occur unannounced.

1. When it is determined by the company that an office site does meet a quality threshold, the company’s designee schedules an office site visit within 30 days and completes the office site visit, including scoring, within 60 days.

2. The following components may be reviewed at the time of the office site visit (**components of each site visit will be determined on a case-by-case basis):**
    a. Physical accessibility to the building, exam rooms and bathrooms
    b. Physical appearance of office location/building
    c. Adequacy of waiting and examining room space including provisions for patient privacy during check in and during examinations
    d. Review of provider/patient interactions (as possible)
    e. Adequacy of medical/clinical record keeping — minimum criteria include policies and processes to protect patient confidentiality of information and medical record documentation including organization of patient's medical record, ability to identify a patient/patient medical record and ability to retrieve a patient medical record.
3. The specific requirements are outlined in the office site visit scoring guidelines and provider site visit scoring tool.
4. The medical director or designee shall notify the provider in writing of the Credentialing Committee's decision. Possible actions include:
    a. Immediate termination from the network.
5. The company's quality management department or designee is responsible for appropriate monitoring and tracking, development of corrective action plans, and reporting to the company Credentialing Committee via the company medical director.
6. The company must conduct a follow-up visit of a previously deficient provider if the provider meets the grievance threshold subsequent to correcting the deficiencies. The standard site visit process outlined in items 1-4 above will be followed.
7. If a recurrent grievance is received on the same practice but is related to a different standard, a site visit will be completed. The site will be evaluated on the specific performance standard pertaining to the current grievance. The standard site visit will follow the process outlined above in items 1-4.

Preventable Adverse Events

The breadth and complexity of today's healthcare system means there are inherent risks, many of which can be neither predicted nor prevented. However, preventable adverse events should be tracked and reduced, with the ultimate goal of eliminating them.

As member advocates, providers and healthcare systems are responsible for the continuous monitoring, implementation and enforcement of applicable healthcare standards. Focusing on patient safety, HealthKeepers, Inc. works collaboratively with providers and hospitals to identify preventable adverse events and to implement appropriate strategies and technologies to avoid them. The goal is to enhance the quality of care received not only by Anthem HealthKeepers Plus members, but all patients receiving care in these facilities.

Prevention of adverse events may require the disclosure of protected health information. HIPAA specifies that PHI can be disclosed for the purpose of healthcare operations in relation to quality assessment and improvement activities. Moreover, the information providers share with HealthKeepers, Inc. is legally protected through the peer review process; it will be maintained in a strictly confidential manner. Medical records requests should be responded to within 10 days from the date of request.

HealthKeepers, Inc. will continue to monitor activities related to the list of adverse events from federal, state and private payers, including never events. A never event is defined by the NQF as adverse events that are serious, but largely preventable, and of concern to both the public and healthcare providers.

Preventable adverse events should not occur. When they do, HealthKeepers, Inc. firmly supports the concept that a health plan and its members should not pay for resultant services and will follow the state policy defined in 42 CFR § 447.26. In addition, according to 42 CFR § 434.6(a)12(i), HealthKeepers, Inc. is prohibited from making a payment to the provider for provider-preventable conditions outlined in 42 CFR § 447.26(b) and requires that the provider report to HealthKeepers, Inc. all provider-preventable conditions or healthcare-acquired conditions associated with claims. Payments for hospital-acquired conditions (HACs) shall be adjusted in the following manner:

- Diagnosis-related group (DRG) cases: The DRG payable will exclude the diagnoses not present on admission (POA) for an HAC.
- Per diem (per diem payments or cost-based reimbursement): The number of covered days will be reduced by the number of days associated with the diagnoses not POA or any HAC. The number of reduced days shall be based on the average length-of-stay (ALOS) on the diagnosis tables published by the ICD vendor used by DMAS.
- No payments shall be made for services for inpatients for the following provider preventable conditions (PPCs):
  - Wrong surgical or other invasive procedure performed on a patient
  - Surgical or other invasive procedure performed on the wrong body part
  - Surgical or otherwise invasive procedure performed on the wrong patient

No reduction in payment for a PPC will be imposed on a provider if the PPC existed prior to the initiation of treatment for that patient by that provider. Nonpayment of PPCs will not prevent access to services for Anthem HealthKeepers Plus members.

CHAPTER 20: ENROLLMENT AND MARKETING RULES

Overview

The delivery of quality healthcare poses numerous challenges, not least of which is the commitment shared by HealthKeepers, Inc. and its providers to protect the members. HealthKeepers, Inc. wants members to make the best healthcare decisions possible for themselves and their families, and when members ask for assistance, provide information and support to help make those decisions without undue influence.

HealthKeepers, Inc. knows that providers occupy a unique, trusted and respected part of people's lives. Given the complexity of modern-day healthcare and the inherent difficulties communicating with some populations, there are potentially serious pitfalls when trying to assist in the decision-making process. Sometimes, even though the intent is to help make members' lives better, individuals can overstep.

For that reason, HealthKeepers, Inc. is committed to following strict enrollment and marketing guidelines created by DMAS and to honor the rules for all state healthcare programs.

Marketing Policies

Providers are prohibited from making marketing presentations and advising or recommending to an eligible individual that he or she select membership in a particular plan. Based on guidance from DMAS, HealthKeepers, Inc. marketing practice policies prohibit providers from making the following false or misleading claims:

- That the PCP's office staff are employees or representatives of the state, county or federal government except in cases the provider is affiliated with or an agent of a state, county or federal government
- That HealthKeepers, Inc. is recommended or endorsed by CMS, the federal government, DMAS or any state or county agency or any other organization
- That the state or county recommends that a prospective member enroll with a specific healthcare plan
- That a prospective member or medical recipient loses Medicaid benefits if the prospective member does not enroll with a specific healthcare plan

Providers are also prohibited from taking the following actions:

- Offering or giving away any form of compensation, reward or loan to a prospective member to induce or procure member enrollment in a specific health care plan
- Engaging in direct marketing to members that is designed to increase enrollment in a particular health care plan
- The prohibition should not constrain providers from engaging in permissible marketing activities (for example, broad outreach objectives and application assistance).

- Using any list of members obtained originally for enrollment purposes from confidential state or county data sources, or from the data sources of other contractors
- Employing marketing practices that discriminate against potential members based on marital status, age, religion, gender, gender identity, national origin, language, gender orientation, ancestry, pre-existing psychiatric problem or medical condition (such as pregnancy, disability or acquired immune deficiency syndrome), other than those specifically excluded from coverage under the HealthKeepers, Inc. contract
- Signing an enrollment application for the member
- Displaying materials only from the provider's contracted managed health care organizations and excluding others

Providers are permitted to:

- Assist the member by directing him or her to call the help lines for enrollment information:
- Cardinal Care Managed Care Help Line: **800-643-2273 (TTY/TDD: 711)** — for members wishing to change managed care companies.
- Use Cover Virginia: **https://www.coverva.org** or **855-242-8282** — for reporting an address change, help with renewals and applying for benefits.
- Anthem HealthKeepers Plus members should contact Maximus at **844-374-9159** (TTY **800-817-6608**), Monday to Friday, 8:30 a.m. to 6 p.m. Distribute copies of Cardinal Care and FAMIS applications to potential members.
- File a complaint if a provider or member objects to any form of marketing, either by other providers or by Anthem HealthKeepers Plus representatives.
- Refer to the **Grievances and Appeals** chapter of this manual for more information on the grievance process.

Enrollment Process: Anthem HealthKeepers Plus and FAMIS Members

DMAS and the Virginia Department of Social Services determine the eligibility and enrollment for Anthem HealthKeepers Plus and FAMIS members. The process is as follows:

1. Managed healthcare plan options are shared with individuals and families eligible for enrollment.
2. Eligible members enroll in the plan of their choice and select a PCP. If the member has not selected a PCP, a PCP is assigned to the member. If members do not elect to enroll in a specific Cardinal Care Managed Care plan, DMAS will auto-assign them to a managed care plan.
3. The enrollment broker informs HealthKeepers, Inc. of new member enrollment, and after enrollment, of any changes in member eligibility, status or contact information (such as an address change).

4. Providers are given notice of new members assigned to their care through monthly eligibility reports. Providers can access these reports by logging into the secure website at **https://providers.anthem.com/va**.
5. HealthKeepers, Inc. sends each new Anthem HealthKeepers Plus member an ID card within five business days of receiving the new member enrollment file. New members also receive a new member packet with program information and a member handbook.

If members fail to renew their coverage then later reapply and are approved, they will automatically return to the same healthcare plan and PCP that they had prior to disenrollment, if available. Members may choose to switch plans.

To support the member enrollment process, PCPs are encouraged to maintain open panels. An open panel is the commitment by contracted providers to accept new Anthem HealthKeepers Plus members.

CHAPTER 21: FRAUD, WASTE AND ABUSE

Overview

HealthKeepers, Inc. is committed to protecting the integrity of the healthcare program and the efficiency of 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.

To help prevent fraud, waste and abuse, providers can assist by educating members. For example, spending time with members and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent member fraud is as simple as reviewing the member identification card. It is the first line of defense against possible fraud. Our company may not accept responsibility for the costs incurred by providers supplying services to a person who is not a member, even if that person presents a member identification card from HealthKeepers, Inc. Providers should take measures to ensure the cardholder is the person named on the card. To learn more visit our consumer fraud education website, **www.fighthealthcarefraud.com**.

Every member identification card lists the following:

- Effective date of membership
- Member date of birth
- Subscriber number (identification number)
- Carrier and group number (RXGRP number) for an injectable
- PCP name, telephone number and address
- Copays for office visits, emergency room visits and pharmacy services (if applicable) (for FAMIS only)
- Behavioral health benefits

- Vision service plan telephone number and dental service plan telephone number
- Member Services and 24/7 NurseLine telephone numbers

Presentation of a member 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 **800-901-0020** for Anthem HealthKeepers Plus.

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 our 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. If you or a patient suspect ID theft, call the Provider Inquiry Line at **800-901-0020**. Providers should instruct their patients who suspect ID theft to watch the EOBs for any errors and contact member services if something is incorrect or to get a replacement member card.

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 reporting the incident and his or her callback number will be kept in strict confidence by investigators.

You can report your concerns by:

- Visiting our www.fighthealthcarefraud.com site; at the top of the page, select **Report it** and complete the Report Waste, Fraud and Abuse form
- Calling our Special Investigations Unit fraud hotline in Virginia at **800-368-3580**.
- Calling Member Services
- Mailing your letter of concern to:

Special Investigations Unit
740 W. Peachtree Street NW
Atlanta, Georgia 30308

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

Examples of Provider Fraud, Waste and Abuse

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

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

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

Examples of Member Fraud, Waste and Abuse

- Forging, altering or selling prescriptions
- Letting someone else use the member's ID card
- Relocating to an out-of-service plan area
- Using someone else's ID card

When reporting concerns involving a member include:

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

Investigation Process

We investigate all reports of fraud, abuse and waste for all services provided under the contract, including those subcontracted to outside entities. If appropriate, allegations and the investigative findings are reported to all the appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste or abuse, which may include but is not limited to:

- *Written warning and/or education*: We send secure/trackable communications to the Provider documenting the issues and the need for improvement. Correspondence may include education or requests for recoveries or may advise of further action.
- *Medical record review*: We review medical records in context to previously submitted claims and/or to substantiate allegations.
- *Prepayment Review*: A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.
- *Recoveries*: We recover overpayments directly from the Provider. Failure of the Provider to return the overpayment may result in reduced payment on future claims and/or further legal action.

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

Instructions for sending paper medical records and/or claims when working with the SIU is found in correspondence from the SIU. If you have questions, contact your investigator. Delays for claim and/or medical record review, and ultimately resolution of an investigation may be delayed if SIU-supplied instructions are not followed. An opportunity to submit claims and medical records electronically is an option if you register for an Availity account. Contact Availity Client Services at **800-AVAILITY** (**282-4548**) for more information.

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

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

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

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

Acting on Investigative Findings
If, after investigation, the SIU determines a Provider appears to have committed fraud, waste, or abuse 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 disenrolled from our healthcare plan, with state approval.

Refer to the **Member Transfers** chapter for more information on the disenrollment process.

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

Credible Allegation of Fraud

In the final rule, CMS provides certain parameters around the credible allegation of fraud in 42 C.F.R. § 455.2. Generally, a credible allegation of fraud may be an allegation that has been verified by the Commonwealth of Virginia, including DMAS or the attorney general's Medicaid Fraud Control Unit (MFCU) that comes from a source including but not limited to:

- Fraud hotline complaints
- Claims data mining.
- Patterns identified through provider audits, civil false claims cases and law enforcement investigations.

Allegations are considered to be credible when they have indicia of reliability, and DMAS or MFCU have reviewed all allegations, facts and evidence carefully.

If HealthKeepers, Inc. receives a notification from DMAS indicating there is a credible allegation of fraud about a provider, HealthKeepers, Inc. is immediately required to place the provider on payment suspension and will not be able to pay the provider until HealthKeepers, Inc. receives notice from DMAS that the credible allegation of fraud is lifted.

Relevant Legislation

False Claims Act

HealthKeepers, Inc. is committed to complying with all applicable federal and state laws, including the federal False Claims Act (FCA).

The FCA is a federal law that allows 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.

The Fraud Enforcement and Recovery Act of 2009 (Public Law No 111-21, May 20, 2009) modified the False Claims Act, requiring providers to refund known overpayments within 60 days of identification.

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 (cumulative from all sources) must comply with the following:

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

HIPAA

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

Our company strives to ensure both HealthKeepers, Inc. and contracted participating providers conduct business in a manner that safeguards member information in accordance with the privacy regulations enacted pursuant to HIPAA. Contracted providers will have the following procedures implemented to demonstrate compliance with HIPAA privacy regulations:

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

CHAPTER 22: MEMBER RIGHTS AND RESPONSIBILITIES

Overview

Members should be clearly informed about their rights and responsibilities in order to make the best healthcare decisions. That includes the right to ask questions about the way HealthKeepers, Inc. conducts business as well as the responsibility to learn about their healthcare coverage.

The following member rights are defined by the Commonwealth of Virginia and appear in the Anthem HealthKeepers Plus member welcome packets and member handbook.

Member Rights

Members have the right to:

- Not be discriminated against on the basis of race, color, national origin, gender, gender identity, age or disability in its health programs and activities, and be treated consistently with their gender identity. Members with limited-English proficiency (LEP) have the right to meaningful access, including qualified interpreter services.
- Receive Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) services; children aged 20 and under may be eligible to receive certain otherwise noncovered services under Medicaid EPSDT provisions. EPSDT covers services which are medically necessary to maintain the member's present condition or improve or correct the condition. These benefits include, but are not limited to, services for nursing care, individualized treatments specific to developmental issues and accessing carved-out services.
- Choose a PCP; members have access to a full range of cost-effective healthcare providers and benefits. They may choose any PCP listed in the Anthem HealthKeepers Plus provider directory to manage their health, as long as that PCP is accepting new patients. PCPs specialize in the areas of general practice, family practice, internal medicine and pediatrics. If the selected PCP terminates his or her relationship with HealthKeepers, Inc., they will be notified via letter prior to the effective date of termination. HealthKeepers, Inc. will assign them a new PCP but they have the right to change their PCP if they are not satisfied with the PCP assignment made. If an Anthem HealthKeepers Plus provider other than their PCP terminates his or her relationship with Anthem HealthKeepers Plus, HealthKeepers, Inc. will notify all affected members prior to the effective date of the termination.
- Be treated with respect; as well as with recognition of their dignity and their right to privacy. HealthKeepers, Inc. abides by Code of Virginia § 32.1-127.1:03 and HIPAA (45 CFR parts 106 and 164) and has a number of procedures in place to ensure member privacy. Any medical information about members that HealthKeepers, Inc. receives, including medical records from healthcare professionals or hospitals, will be kept confidential and, except as permitted by law, will not be made available to anyone without written permission of the member. Members can review any

personal information HealthKeepers, Inc. collects about them and corrections can be made at the members' request.

- Receive prompt treatment and service; members should always be treated promptly, with courtesy and respect, by their healthcare providers. Likewise, when they have questions or need help with their plan benefits, they should always receive prompt and courteous service from Anthem HealthKeepers Plus employees.
- Know about all their treatment options and alternatives and to participate with providers in making decisions about their healthcare. Members have the right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Participate with practitioners in making decisions about their healthcare; HealthKeepers, Inc. encourages members to discuss each treatment option/alternative with their doctor and to participate in the decision about their course of care.
- Refuse treatment and be told of the possible results of refusing treatments, including whether refusals may result in disenrollment with HealthKeepers, Inc.
- Voice complaints or appeals about the organization or the care it provides; Member Services staff can resolve most member concerns if they are ever dissatisfied with HealthKeepers, Inc. or the care they have received from a participating healthcare professional.
- File a complaint or appeal a decision; in order to remain responsive to member needs, HealthKeepers, Inc. has established both a complaint and an appeal process.
- Request and receive information about the organization, its services, its practitioners and providers and member's rights and responsibilities; HealthKeepers, Inc. may also periodically send members information on how to use the benefits and features of their health plan.
- Request and receive a copy of their medical records at any time from their provider. HealthKeepers, Inc. can also assist members in getting medical records.
- Request that their medical records be amended or corrected.
- Make recommendations regarding the organization's member rights and responsibilities policy; being a partner in their healthcare means remaining involved in, and informed about, the decisions that affect their health. HealthKeepers, Inc. welcomes all suggestions regarding what member rights and responsibilities should be, as well as what the plan's rights and responsibilities should be.
- Contact Member Services staff with any questions, concerns or suggestions.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion.
- Have free exercise of their rights, and the exercise of those rights does not adversely affect the way HealthKeepers, Inc. and its providers treat them.

- Be provided information about advance directives as required in 42 CFR§§ 489.102 and 422.128.
- Make an advance directive, or living will.
- Be furnished healthcare services in accordance with federal regulations 42 CFR §§ 438.206 through 438.210.

Member Responsibilities

Members have the responsibility:

- To select their PCP when they enroll, and maintain a designated PCP as long as they are an Anthem HealthKeepers Plus member. If they do not select a PCP upon enrollment or if the PCP they previously selected terminates his or her relationship with the Anthem HealthKeepers Plus network, HealthKeepers, Inc. will select a PCP for them.
- Of getting to know their PCP; establishing a personal and continuous relationship with their PCP is an essential part of maintaining good health, because it allows them to become more familiar with their individual healthcare needs.
- To use only their PCP and in-network providers; because their PCP is responsible for managing their health, they should see their PCP before receiving nonemergency services from any healthcare provider. If they need care from a specialist, their PCP will refer them to an appropriate healthcare professional.
- Of understanding their health problems and participating in developing mutually agreed upon treatment goals, to the degree possible; it is important that members work together with providers and their staff to be a partner in their healthcare and follow their advice and the care they recommend.
- Of taking the necessary steps to have their previous medical records and any updates transferred to their current doctor.
- To supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care; in addition, if they have any plan, they should discuss it with their provider.
- To follow plans and instructions for care that they have agreed to with their practitioners.
- To understand the medications they are taking and whether they are scheduled for follow-up visits.
- To keep all diagnostic or treatment appointments as scheduled; members are expected to be on time for appointments. When they cannot attend an appointment, members are expected to cancel appointments 24 hours in advance.
- To understand their ID card, carry it with them at all times and present the card whenever they receive covered services.
- To ensure only they use their ID card.
- To know what is considered emergency care and what is considered urgent care; members should know when to use the emergency room for care and when to seek care from their PCP.

If a provider would like additional information regarding member rights and responsibilities, they can call Anthem HealthKeepers Plus Provider Services at **800-901-0020**. Members with hearing or speech loss may call TTY **711**.

CHAPTER 23: CULTURAL DIVERSITY & LINGUISTIC SERVICES

Overview

HealthKeepers, Inc. recognizes providing healthcare services to a diverse population can present challenges. Those challenges arise when providers need to cross a cultural divide to treat members who may have different behaviors, attitudes and beliefs concerning healthcare. Differences in members' ability to read may add an extra dimension of difficulty when providers try to encourage follow-through on treatment plans.

The Anthem HealthKeepers Plus Cultural Competency Toolkit was developed to give providers specific tools for breaking through cultural and language barriers and better communicate with patients. Sometimes the solution is as simple as finding the right interpreter for an office visit. Other times, a greater awareness of cultural sensitivities can open the door to the kind of interaction that makes treatment plans most effective. Has the patient been raised in a culture that frowns upon direct eye contact? Or receiving medical treatment from a member of the opposite sex? Is the patient self-conscious about his or her ability to read instructions?

The toolkit gives providers the information they will need to answer those questions and continue building trust. It will enhance the ability to communicate with ease, talking to a wide range of people about a variety of culturally sensitive topics, and it offers cultural and linguistic training to office staff, so that all aspects of an office visit can go smoothly.

HealthKeepers, Inc. strongly encourages providers to access the complete **Cultural Competency Toolkit** at **Provider Training Academy | HealthKeepers, Inc. (anthem.com)**

The toolkit contents are organized into the following sections:

Improving Communications with a Diverse Patient Base

- Encounter tips for providers and their clinical staff
- A mnemonic to assist with patient interviews
- Help in identifying literacy problems

Tools and Training for Your Office in Caring for a Diverse Patient Base

- Interview guide for hiring clinical staff who have an awareness of cultural competency issues
- Availability of medical consumerism training for health educators to share with patients
- Resources to communicate across language barriers

Tips for Locating and Working with Interpreters

- Common signs and common sentences in many languages
- Language identification flashcards
- Language skill self-assessment tools

Primer on How Cultural Background Impacts Health Care Delivery

- Tips for talking with people across cultures about a variety of culturally sensitive topics
- Information about different cultural backgrounds' healthcare beliefs

Regulations and Standards for Cultural and Linguistic Services

- Important legislation impacting cultural and linguistic services, including a summary of the Culturally and Linguistically Appropriate Service standards (CLAS), which serve as a guide on how to meet these requirements

Resources for Cultural and Linguistic Services

- A bibliography of print and internet resources for conducting an assessment of the cultural and linguistic needs of providers' patient population
- Staff and physician cultural and linguistic competency training resources
- Links to additional tools in multiple languages and/or written for individuals with limited English proficiency

This toolkit contains materials developed by and used with the permission of the Industry Collaboration Effort (ICE) Cultural and Linguistic Workgroup – a volunteer, multidisciplinary team of providers, health plans, associations, state and federal agencies and accrediting bodies working collaboratively to improve healthcare regulatory compliance through public education.

Interpreter Services

For those instances when providers cannot communicate with a member due to language barriers, interpreter services, including over-the-phone and face-to-face interpreters, are available at no cost to the provider or member. Providers must notify members of the availability of interpreter services and strongly discourage the use of friends and family, particularly minors, to act as interpreters. Face-to-face interpreters for members needing language assistance, including American Sign Language, can be scheduled up to one month in advance and no less than five days before a routine visit or 24 hours prior to rendering acute care services.

To request interpreter services, Anthem HealthKeepers Plus providers and members should call **800-901-0020 (**TTY **711)**. For after-hours interpreter services, Anthem

HealthKeepers Plus members can call the 24/7 NurseLine at **800-901-0020 (**TTY **711)** and follow these steps:

1. Give the customer care associate the member's ID number.
2. Explain the need for an interpreter and state the language.
3. Wait on the line while the connection is made.
4. Once connected to the interpreter, the associate or 24/7 NurseLine nurse introduces the member, explains the reason for the call and begins the dialogue.

For TTY and relay services, the Virginia relay service is available 24/7 by calling **800-743-3333 (TTY 711)**.

Americans with Disabilities Act

Providers must comply with all applicable federal and state laws in assuring accessibility to all services for members with disabilities, pursuant to the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973, maintaining the capacity to deliver services in a manner that accommodates the needs of its members. Providers contracted with HealthKeepers, Inc. are required by law to provide disabled persons full and equal access to medical services.

Although a review of the requirements of the law and implementing regulations can be daunting, providing full and equal access to persons with disabilities can be achieved by:

- Removing physical barriers.
- Providing means for effective communication with people who have vision, hearing or speech disabilities, including providing auxiliary aids as needed.
- Providing flexibility in scheduling to accommodate people with disabilities.
- Allowing extra time for members with disabilities to dress and undress, transfer to examination tables, and extra time with the provider in order to ensure the individual is fully participating and understands the information.
- Making reasonable modifications to policies, practices and procedures.

For more information on making changes to a practice to ensure ADA compliance, providers can refer to HealthKeepers, Inc.'s ADA provider training, which is available on the provider website at **https://providers.anthem.com/va**.

Providers can also refer to these additional resources:

- **https://www.professionalsadvocate.com/resources**
- **https://www.ada.gov**
- **https://www.ada.gov/medcare_mobility_ta/medcare_ta.htm**

APPENDIX A: CREDENTIALING AND RECREDENTIALING

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Overview

The credentialing requirements for Anthem HealthKeepers Plus providers follow the credentialing requirements for all lines of business and products offered by HealthKeepers, Inc.; HealthKeepers, Inc. does not have credentialing requirements for FAMIS or Cardinal Care that are separate and distinct from other HealthKeepers, Inc. products, unless specifically required by our contract with DMAS.

HealthKeepers, Inc.'s Discretion

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

Definitions

AAAHC: Accreditation Association for Ambulatory Health Care

QUAD A: American Association for Accreditation of Ambulatory Surgery Facilities

AANP: American Association of Nurse Practitioners

AAMFT: American Association for Marriage and Family Therapy

AAPSF: Accreditation Association for Podiatric Surgical Facilities

ABCOP: American Board for Certification in Orthotics and Prosthetics

ABCN: American Board of Clinical Neuropsychology

ABMS: American Board of Medical Specialties

ABN: American Board of Professional Neuropsychology

ACHC: Accreditation Commission for Health Care

ACPE: Association for Clinical Pastoral Education

Administrative Action: A decision to terminate or reject a Practitioner, Provider or HDO from network participation for which HealthKeepers, Inc.'s basis for action is based on something other than the competence or professional conduct of a Provider, which affects or could adversely affect the health or welfare of a patient.

Adverse Administrative Action: A Company decision to terminate or reject a provider from network participation for other than a Professional Review Action.

Adverse Credentialing Decision: A Company decision to deny initial application or terminate a currently credentialed Provider's network participation when information

reviewed during initial credentialing, re-credentialing or ongoing monitoring indicates that credentialing, re-credentialing or ongoing monitoring requirements are not met.

Enterprise: Refers to Anthem, Inc., and its Affiliates.

ANCC: American Nurses Credentialing Center

Anthem: also referred to as the "Company." Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield and/or those companies that are under common control with Anthem Health Plans of Virginia, Inc.

Enterprise Medical Directors: Those medical directors with responsibility for the Medical Operations and Quality Management activities of the various companies of HealthKeepers, Inc.

AOA: American Osteopathic Association

Attestation: A signed statement indicating that a practitioner or HDO designee personally confirmed the validity, correctness, and completeness of his, her or its credentialing application at the time that he, she or it applied for participation.

BACB: Behavior Analyst Certification Board

BOC: Board of Certification/Accreditation

CABC: Commission for the Accreditation of Birth Centers

CARF: Commission on Accreditation of Rehabilitation Facilities

CCMHC: Certified Clinical Mental Health Counselor **Certification review**: verification of criteria required for practice, training, and/or delivery of clinical services, including but not limited to licensure, and/or compliance with regulatory requirements and/or state or federal contract requirements for provision of such services.

CHAP: Community Health Accreditation Program

CIHQ: Center for Improvement in Healthcare Quality

Clinical Peer: A Practitioner, not otherwise involved in HealthKeepers, Inc.'s network management, whose practice is in the same or a similar Specialty.

COA: Council on Accreditation

TCT: The Compliance Team

HealthKeepers, Inc. Credentials Committee (CC): A local multi-disciplinary committee that has representation from appropriate types of practitioners and specialties.

Credentialing staff: Any associate in the HealthKeepers, Inc. Credentialing Department.

DNV NIAHO: Det Norske Veritas (DNV) Healthcare, Inc. NIAHO National Integrated Hospital Accreditation for Healthcare Organizations Program

For Cause Termination: A termination related (1) failure of a Provider to meet predetermined credentialing criteria related to professional conduct and competence; (2) quality of care; (3) patient safety; and (4) professional conduct or competence which affects or could adversely affect the health or welfare of a patient and/or that in the determination of the CC poses some potential risk to the health of the HealthKeepers, Inc.'s Members.

Formal Appeal: The process by which HealthKeepers, Inc.'s Adverse Credentialing Decision is challenged.

Health Delivery Organization (HDO): A facility, institution or entity that is licensed or certified (as applicable), in accordance with all applicable state and/or federal laws, that provides or delivers healthcare services.

HQAA: Healthcare Quality Association on Accreditation

Immediate Termination: a termination of network participation which is effective immediately. It occurs prior to review by the geographic Credentials Committee, and prior to the Provider being allowed an appeal, if applicable. It is used when determined necessary by HealthKeepers, Inc. to protect against imminent danger to the health or welfare of HealthKeepers, Inc.'s Members or a Provider has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs.

Termination due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB programs do not go to the geographic Credentials Committee for review are not eligible for Informal Review/Reconsideration or Formal Appeal (see Credentialing Policies #13 and 14).

Informal Review/Reconsideration: A process through which an initial applicant or participating provider submits additional information to HealthKeepers, Inc. to correct or augment the information which resulted in an Adverse Administrative Action or Adverse Credentialing Decision. Reviewer(s) may be the same person(s) who were part of the original decision. As part of the Informal Review/Reconsideration, HealthKeepers, Inc., at its discretion, may afford additional privileges to the practitioner or HDO, such as by way of example only, an opportunity to discuss the decision with an HealthKeepers, Inc. representative telephonically. In any event, an Informal Review/Reconsideration shall not include privileges equal to or greater than those offered in a Formal Appeal.

Initial Applicant: Any person or organization that provides healthcare services which has applied for participation with HealthKeepers, Inc. to provide healthcare services to HealthKeepers, Inc.'s Members.

Members: Refers to Members or Covered Individuals.

Mental Health Condition: A condition that may impair the individual's judgment or emotional stability. Any disturbance of emotional equilibrium, as manifested in maladaptive behavior and impaired functioning caused by genetic, physical, chemical, biologic, psychological, or social and cultural factors.

NAADAC: National Association for Alcoholism and Drug Abuse Counselors

National Practitioner Data Bank (NPDB): A federal data bank maintained by the U.S. Department of Health & Human Services, or its authorized contractor, which houses information regarding Providers and any state or federal sanctions, closed malpractice cases where findings are for the plaintiff, settlements and hospital privilege actions.

National Register of Health Service Providers in Psychology (a.k.a. The Register): An organization providing primary source verification for education and training and Board Certification of psychologists. This entity has "deemed status" from NCQA.

NBCC: National Board of Certified Counselors

NEBO: The National Examining Board of Ocularists

NCCPA: National Commission on Certification of Physician Assistants

Notice: Any notice or notification required to be provided to a Practitioner or Health Delivery Organization as part of the Credentialing Policies shall be in writing and delivered by hand, facsimile, electronic mail, mail, or web portal, unless specifically stated otherwise in the applicable policy.

Participating Provider: Any person or organization that provides healthcare services and which has credentialed by and has entered into an agreement with HealthKeepers, Inc.to provide healthcare services to Company's Members.

Peer Review: Evaluation or review of the professional competency and conduct of colleagues by professionals with similar types and degrees of expertise (for example, the evaluation of one physician's practice by another physician)

Physical Condition or Impairment: A physical disability or presence of an illness that may interfere with a Practitioner's ability to practice to the fullest extent of their Specialty with or without accommodation or that could pose a risk of harm for patients.

PNCB: Pediatric Nursing Certification Board

Practitioner: An individual person who is licensed or certified (as applicable) in accordance with all applicable state and federal laws to deliver healthcare services.

Professional Conduct and Competence Review: peer review by the geographic Credentialing Committee that assesses a Provider's conduct and qualifications in accordance with HealthKeepers, Inc. Credentialing Policies.

Professional Review Action: A decision to terminate or reject a Provider from network participation that is based on the competence or professional conduct of a Provider which affects or could adversely affect the health or welfare of a patient.

Provider: Any licensed or certified (as applicable) person or institution that provides healthcare services, including practitioners and HDOs.

Substance Use Disorder Condition: A condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on legal or illegal drugs which results in a chronic disorder affecting physical health and/or personal or social functioning.

TJC: The Joint Commission

Policy 1: Credentialing Program Structure

A. The National Credentials Committee (NCC) establishes the policies and procedures for:
   1. Credentialing, re-credentialing, ongoing monitoring and oversight of network practitioners and HDOs; and
   2. The delegation of credentialing related activities; and
   3. Appeals of adverse credentialing decisions; and
   4. Review of HealthKeepers, Inc.'s clinical staff qualifications and approval for those staff to perform clinical functions on behalf of HealthKeepers, Inc.

B. The NCC policies will:
   1. Comply with relevant federal law; and
   2. Meet standards set by relevant regulatory and accrediting bodies; and
   3. Be modified for state specific use to comply with state law where applicable; and
   4. Be reviewed at least annually, and revised as necessary.

C. The NCC is:
   1. Composed of ten to twelve Company medical directors selected to represent various clinical and business areas of HealthKeepers, Inc.; representation shall include the following:
      a. At least two medical directors representing Commercial and Medicaid lines of business, respectively, and one medical director representing Medicare line of business; and
      b. At least one medical director representing behavioral health; and
      c. At least two medical directors who act as chairs/vice-chairs of geographic Credentials Committees (as detailed in Credentialing Policy #3); and
   2. Chaired by an HealthKeepers, Inc. medical director as designated by the Vice President (VP) responsible for Enterprise Credentialing Policy. The VP responsible for Enterprise Credentialing Policy reports to HealthKeepers, Inc. Chief Medical Officer.

D. HealthKeepers, Inc. shall:
   1. Maintain an appropriate staff to implement credentialing policy; and
   2. Establish a geographic Credentials Committee (CC) (as detailed in Credentialing Policy #3) to perform credentialing review of practitioners and HDOs and render determinations; and
   3. Review and provide input on the policies established by the NCC; and
   4. Adopt and implement the policies and procedures set forth by the NCC.

E. HealthKeepers, Inc. establishes a local credentialing and peer review body known as the geographic Credentials Committee (CC). The CC is authorized by the NCC to evaluate and determine eligibility for practitioners and HDOs to participate in HealthKeepers, Inc.'s credentialed provider network(s) and be listed in HealthKeepers, Inc.'s provider directories. The CC's functions are governed by Enterprise HealthKeepers, Inc. Credentialing Policy and are supported by HealthKeepers, Inc. credentials staff (see credentialing Policy #3).

Policy 2: Credentialing Program Scope

Credentialing requirements apply:

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

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

- Individual or group practices.
- Locum tenens:
  - Provisional Credentialing is required if these practitioners work less than 60 calendar days.
  - Full Credentialing is required if these practitioners work 60 calendar days or more.
- Facilities.
- Rental networks:
  - That are part of the organization's primary network and the organization has Members who reside in the rental network area.
  - Specifically for out-of-area care and Members may see only those practitioners or are given an incentive to see rental network practitioners.
- Telemedicine.

Professional Practitioners:

A. Practitioners Types: HealthKeepers, Inc. credentials the following types of licensed/state-certified independent healthcare practitioners when the exclusions in section b(see below) do not apply:
   - Medical Doctors (MD) and Doctors of Osteopathic Medicine (DO);
   - Doctors of Podiatry;
   - Chiropractors;

- Optometrists providing Health Services covered under the Health Benefits Plan;
- Oral and Maxillofacial surgeons
- Psychologists who are state certified or licensed and have doctoral or master's level training;
- Clinical social workers who are state certified or state licensed and have master's level training;
- Psychiatric nurse practitioners who are nationally or state certified or state licensed or behavioral nurse specialists with master's level training;
- Other behavioral health care specialists who are licensed, certified or registered by the state to practice independently;
- Telemedicine practitioners who have an independent relationship with the Company and who provide treatment services under the Company's medical benefit
- Medical therapists(for example, physical therapists, speech therapists, and occupational therapists;
- Genetic Counselors;
- Audiologists who are licensed by the state to practice independently;
- Acupuncturists (non-MD/DO) who are licensed, certified or registered by the state to practice independently
- Nurse practitioners;
- Certified nurse midwives;
- Physician assistants;
- Registered Dietitians.

B. Practitioners with whom HealthKeepers, Inc. has a contractual relationship do not require credentialing when the Practitioner:
   - Practices exclusively in an inpatient setting and provides care for Members only because Members are directed to the hospital or another inpatient setting; OR
   - Practices exclusively in free-standing facilities and provides care for Members only because Members are directed to the facility.

   Examples of this type of practitioner include, but are not limited to:
   - Pathologists
   - Radiologists
   - Anesthesiologists
   - Neonatologists
   - Emergency Room Physicians
   - Urgent Care Physicians
   - Urgent Care Center mid-level providers (for example, nurse practitioners, physician assistants)
   - Hospitalists
   - Pediatric Intensive Care Specialists
   - Other Intensive Care Specialists

- Pharmacists who work for a pharmacy benefits management (PBM) organization to which the Company delegates utilization management (UM) functions.
- Covering practitioners (e.g., locum tenens) who do not have an independent relationship with the Company.
- Practitioners who do not provide care for members.
- Rental network practitioners who provide out-of-area care only and members are not required or given an incentive to seek care from them.

C. The following behavioral health practitioner types are not subject to professional conduct and competence review under HealthKeepers, Inc.'s Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services:
   - Certified Behavioral Analysts;
   - Certified Addiction Counselors;
   - Substance Use Disorder Practitioners.

   Note: an individual who is contracted and practices in the office setting must be credentialed when that practitioner meets criteria in section b of this Credentialing Policy, above.

Healthcare Delivery Organizations (HDOs):

A. HealthKeepers, Inc. credentials the following types of HDOs:
   - Hospitals;
   - Home Health Agencies;
   - Skilled Nursing Facilities (Nursing Homes);
   - Ambulatory Surgical Centers;
   - Behavioral Health Facilities providing mental health and/or Substance Use Disorder treatment in inpatient, residential or ambulatory settings:
     - Adult Family Care/Foster Care Homes;
     - Ambulatory Detox;
     - Community Mental Health Centers (CMHC);
     - Crisis Stabilization Units;
     - Intensive Family Intervention Services;
     - Intensive Outpatient – Mental Health and/or Substance Use Disorder;
     - Methadone Maintenance Clinics;
     - Outpatient Mental Health Clinics;
     - Outpatient Substance Use Disorder Clinics;
     - Partial Hospitalization – Mental Health and/or Substance Use Disorder;
     - Residential Treatment Centers (RTC) – Psychiatric and/or Substance Use Disorder;
   - Birthing Centers;

- Home Infusion Therapy when not associated with another currently credentialed HDO;
- Durable Medical Equipment Providers

B. The following Health Delivery Organizations are not subject to professional conduct and competence review under HealthKeepers, Inc.'s Credentialing Program, but are subject to a certification requirement process:
   - Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)
   - End Stage Renal Disease (ESRD) service providers (dialysis facilities) (CMS Certification or National Dialysis Accreditation Commission))
   - Hospices (CMS Certification)
   - Portable x-ray Suppliers (CMS Certification)
   - Federally Qualified Health Centers (FQHC); (CMS Certification)
   - Rural Health Clinics; (CMS Certification)
   - Home Infusion Therapy when associated with another currently credentialed HDO (CMS Certification)
   - Orthotics and Prosthetics Suppliers (American Board for Certification in Orthotics and Prosthetics_(ABCOP) or Board of Certification/Accreditation (BOC) or The National Examining Board of Ocularists (NEBO))

Policy 3: Credentials Committee

1. All credentialing determinations are made by HealthKeepers, Inc.'s Credentials Committee (CC), which reports to HealthKeepers, Inc.'s governing board. The CC is authorized, under authority from the governing body of HealthKeepers, Inc. and under the direction of the Chief Medical Officer of HealthKeepers, Inc., to evaluate all healthcare Practitioners and Healthcare Delivery Organizations (HDOs) within the scope the Credentialing Program applying for participation or seeking continued participation in the HealthKeepers, Inc. network.
2. These applicants will be reviewed for issues related to their meeting the Company's established credentialing criteria. The CC may authorize the chair/vice-chair or a designated HealthKeepers, Inc. Medical Director to approve providers meeting all predetermined criteria for credentialing or re-credentialing. Upon individual review of providers not meeting predetermined criteria, the CC may accept or deny those Practitioners or HDOs initially applying for participation, and to retain or terminate those Practitioners or HDOs requesting continued participation in the Company's programs or provider network(s).
3. The CC is composed of:
   - At least five (but no more than ten) external participating physicians representing multiple medical specialties:

- In general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair.
- Exception: representation of a specialty or practice-type is not required if: That specialty or practice-type is not provided in the geographic region represented by the CC; or
  - That specialty or practice-type representation cannot be achieved because of recruitment difficulties AND the chair/vice-chair of the CC deems that ad hoc representation of said specialty or practice-type can be achieved by external consultation as needed to complete the review of credentials of a Practitioner.
  - Committee membership may, but does not necessarily also include one to two other types of credentialed health providers (for example, nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair's discretion (for example, volume of providers types in the region).
  - At least two of the physician committee members must be credentialed for each line of business (for example, Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC; AND
  - A chair, designated after review and approval by the chair of the National Credentials Committee (NCC), who is a state or regional lead medical director, or an HealthKeepers, Inc. Associate designee directly thereof; AND
  - A vice-chair, designated after review and approval by the chair of the NCC, in states or regions where both Commercial and Medicaid contracts exist, who is the lead medical officer or a HealthKeepers, Inc. Associate designee directly thereof, for that line of business not represented by the chair.

Note:

- In states or regions where only one line of business is represented, the chair of the CC will designate after review and approval by the chair of the NCC, a vice-chair, who is a HealthKeepers, Inc. medical director, for that line of business represented by the chair.
- In states or regions where Medicare Advantage (MA) is represented, a second vice-chair representing MA may be designated after review and approval by the chair of the NCC.
- In states or regions where an HealthKeepers, Inc. affiliated provider organization is represented, a second vice-chair representing that organization may be designated after review and approval by the chair of the NCC.

The CC will meet, at minimum, as often as necessary to meet the requirements of accreditation, regulation, or contract, but in any event at least once every forty-five (45) calendar days. The presence of a majority of voting CC members constitutes a quorum.

The chair/vice-chair, as outlined in policy (above), will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed. This support may include availability to respond to questions regarding specific cases, assistance with committee preparations, participation activities regarding immediate termination process (see Credentialing Policy #10), appeals (See Credentialing Policy #13), and ongoing monitoring (see Credentialing Policy #12). The CC shall include participating Practitioners as outlined in policy (above). The chair/vice-chair of the CC may appoint additional participating Practitioners of a particular specialty type as deemed appropriate for the efficient functioning of the Anthem's Credentialing Committee, and in conjunction with policy (above).

The CC will access various specialists for consultation, as needed to complete the review of a Practitioner's credentials where the committee deems it appropriate.

A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the Practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the Practitioner.

New committee members shall sign a statement that they do not and will not discriminate in the discharge of their duties on the Credentials Committee.

If a current or previous member of the CC requires committee review for any reason, the review will not be performed by the CC on which the practitioner participated. The review will occur at the CC of an HealthKeepers, Inc. affiliate.

Determinations to deny an applicant's participation or terminate a practitioner from participation in one or more Networks or Plan Programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are participating Network practitioners.

Practitioners and HDOs who meet all participation criteria for initial or continued participation (including off-cycle review) and whose credentials have been satisfactorily verified by the Credentialing department may be approved by the chair/vice-chair of the CC after review of the applicable credentialing or re-credentialing information. This information may be in summary form and must include, at a minimum, Practitioner's name and specialty.

Practitioners and HDOs who (1) do not meet all of HealthKeepers, Inc.'s participation or credentialing criteria, or (2) have other issues that require individual consideration, are presented to the CC for individual review. If the CC requests additional information, HealthKeepers, Inc.'s credentialing staff will collect follow-up information and add it to

the applicable Practitioner's file. The file is then resubmitted to the CC for reconsideration at its next meeting.

The Committee may discuss whether the information submitted as part of the application, or reapplication process appears to support that the providers are meeting reasonable standards of professional competence and conduct.

Individuals engaged in credentialing activities by or on behalf of HealthKeepers Inc. shall maintain the confidentiality of all information developed or presented as part of the credentialing process. Access to information will be restricted to those individuals who are deemed necessary to attain the objectives of the HealthKeepers Inc's credentialing program. In particular, information supplied by the Practitioner or HDO in the application, as well as other non-publicly available information will remain confidential. Confidential written records regarding deficiencies found, the actions taken, and the recommended follow-up will be kept in a secure fashion. Security mechanisms include secured office facilities and locked filing cabinets, a protected computer infrastructure with password controls and systematic monitoring, and staff ethics and compliance training programs. The procedures and minutes of the CC will be open to review by state and federal regulating agencies and accrediting bodies to the extent permitted by law.

Providers requesting initial participation will be notified of the decision by appropriate HealthKeepers, Inc. personnel within sixty (60) days of receipt of a completed application or within 30 days of the CC decision, whichever is earlier. This notification may occur electronically or via standard mail.

Policy 4: Professional Competence and Conduct Criteria – Practitioners

Each healthcare practitioner applying for initial credentialing or re-credentialing must satisfy the applicable eligibility criteria regarding professional conduct and competence to participate in one or more of HealthKeepers, Inc.'s programs or provider network(s). Eligibility criteria can be separated into two categories: (1) criteria not subject to committee review (must be met); and (2) criteria subject to appropriate standards of professional conduct and competence as reviewed and determined by a peer committee. The latter must be reviewed and approved by the geographic Credentials Committee (CC). Practitioners within scope of credentialing policy are listed in Credentialing Policy #2.

The NCC determines the practitioner types defined within scope of HealthKeepers, Inc.'s Credentialing Program, as established by, but not limited to: perceived risk to Members and volume of services rendered.

Note: Additional practitioner types, when explicitly required by specific regulatory or contractual obligations, may be reviewed according to contractual requirements and/or local, state, and federal regulations; however, such review lies outside the scope of this Credentialing Policy #4.0.

Health Care Practitioners

Eligibility Criteria Not Subject to Committee Review – all healthcare practitioners within the scope of HealthKeepers, Inc.'s Credentialing Program applying for participation in HealthKeepers, Inc.'s programs or provider network(s) must meet the following criteria in order to be considered for participation. Applicants for initial participation in HealthKeepers, Inc.'s programs or provider network(s) who do not meet the criteria below will be notified of this failure to meet criteria and their applications will not proceed through the credentialing process.

A. Must not be currently sanctioned, debarred or excluded from participation in any of the following programs, Medicare, Medicaid or the Federal Employees Health Benefits Program (FEHBP). **Note:** If, once a practitioner participates in HealthKeepers, Inc.'s programs or provider network(s), debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the practitioner will become immediately ineligible for participation in the applicable government programs or provider network(s) as well as HealthKeepers, Inc.'s other credentialed provider network(s).
B. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he/she provides services to HealthKeepers, Inc.'s Members; unless an exception to this requirement applies (see below).
C. Possess a current, valid, and unrestricted DEA or CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat HealthKeepers, Inc.'s Members (see list below for practitioner types who do not require a DEA or CDS); unless an exception to this requirement applies. The DEA/CDS must be valid in the state(s) in which the practitioner will be seeing HealthKeepers, Inc.'s Members. Practitioners who see Members in more than one state must have a DEA/CDS for each state.
D. Meet the education, training and certification criteria as required by HealthKeepers, Inc. Criteria subject to appropriate standards of professional conduct and competence as reviewed and determined by a peer committee – all healthcare practitioners within the scope of HealthKeepers, Inc.'s Credentialing Program applying for participation in HealthKeepers, Inc.'s programs or provider network(s) must meet the following criteria in order to be considered for participation. If an applicant for initial participation or continued participation in HealthKeepers, Inc.'s programs or provider network(s) does not meet one or more of the following criteria, the applicant's history must not raise a reasonable suspicion of future substandard professional conduct and/or competence. The CC will consider the applicant's history on an individual basis pursuant to Credentialing Policy.
    1. Exception to state license requirements may be made in the following instances:

a. For initial applicants whose licensure action was related to substance use disorder, physical impairment or mental illness and that have demonstrated a minimum of two years of successful participation in a treatment and/or monitoring program with no evidence of recidivism, recurrence or relapse since the institution of the treatment/monitoring. In the event this exception is considered, HealthKeepers, Inc. may request specific documentation from the treating physician and/or program as it deems appropriate, as detailed in Credentialing Policy #16. These applicants will be subject to review per Credentialing Policy.
b. For applicants previously terminated from HealthKeepers, Inc.'s provider network(s) related to licensure action for substance use disorder per Credentialing Policy #16, that have demonstrated a minimum of one (1) year of successful participation in a treatment and/or monitoring program with no evidence of recidivism since that time. Should this exception be entertained, HealthKeepers, Inc. may request specific documentation from the treating physician and/or program as it deems appropriate. These applicants will be subject to review per Credentialing Policy.
c. In jurisdictions where the licensing entity issues licenses to new applicants at a frequency less than monthly, but does issue temporary licenses, HealthKeepers, Inc. may at its discretion, accept a temporary license. In instances where a temporary license is accepted, HealthKeepers, Inc. will also establish a timeframe in which a permanent license is required. These will be viewed as Level I files and will not require Credentials Committee review. HealthKeepers, Inc. will view any encumbrances, probations or other restrictive actions taken against such an applicant as not meeting criteria.
d. In jurisdictions where the licensing entity issues a limited license with geographic limitations that are unrelated to professional conduct or competence (for example, immigration status), HealthKeepers, Inc. may, at its discretion accept a limited license. These will be viewed as Level I s and will not require Credentials Committee review. HealthKeepers, Inc. will view any encumbrances, probations or other restrictive actions taken against such an applicant as not meeting criteria.
e. Indian Health Services (IHS) practitioners who provide services in states which recognize HIS licensure as a proxy for the Practitioner's state licensure do not require a same state license. The IHS license will be verified and documentation showing state acceptance of the IHS license will be recorded.

2. An exception to DEA or CDS registration requirements may be made in the following instances: (**Note:** For practitioner types who do not require a DEA or CDS registration see below. In the event that any of these practitioners do have a DEA or CDS registration, it will be subject to verification).
   a. For initial applicants who voluntarily have no DEA/CDS registration, the exception listed below in section 3 may apply. Or, if the applicant can provide

evidence that he has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:

1. Verification that the applicant's DEA/CDS application is pending;
2. The applicant has made an arrangement for an alternative Provider to prescribe controlled substances until the additional DEA/CDS registration is obtained. If the alternate provider is a practice rather than an individual, the file may include the practice name. HealthKeepers, Inc. is not required to arrange an alternative prescriber;
3. The applicant agrees to notify HealthKeepers, Inc upon receipt of the required DEA/CDS registration;
4. Verification of the appropriate DEA/CDS via standard sources; and
5. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a ninety (90) day timeframe will result in termination from the network.

b. For initial applicants who possess a DEA certificate in a state other than the state in which they will be seeing HealthKeepers, Inc.'s members will be notified of the need to obtain the additional DEA. If the applicant has applied for an additional DEA registration, the credentialing process may proceed if all the following criteria are met:
    1. Verification that the applicant's DEA application is pending;
    2. The applicant has made an arrangement for an alternative Provider to prescribe controlled substances until the additional DEA registration is obtained;
    3. The applicant agrees to notify HealthKeepers, Inc. upon receipt of the required DEA registration;
    4. Verification of the appropriate DEA/CDS registration via standard sources; and
    5. The applicant agrees that failure to provide the appropriate DEA registration within a ninety (90) day timeframe will result in termination from the network.
c. Practitioners, excluding those practitioners and physician specialties listed on Attachment B, who voluntarily choose to not have a DEA/CDS registration, if that Practitioner certifies the following (i and either ii or iii):
    i. DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than voluntary choice.
    ii. Controlled substances are not prescribed within their scope of practice, or in their professional judgement, the patients receiving their care do not require controlled substances, and Practitioner provides documentation to HealthKeepers, Inc. that describes their process for handling instances when a patient requires a controlled substance; OR

iii. Prescribing controlled substance is in the scope of practice but the Practitioner provides documentation to HealthKeepers Inc. that an arrangement exists for an alternative Provider to prescribe controlled substances if it is clinically appropriate. If the alternate provider is a practice rather than an individual, the file may include the practice name. HealthKeepers Inc. is not required to arrange an alternative prescriber.

Practitioner Types and Physician Specialties Not Requiring DEA and CDS Registration

1. Allergy and Immunology
2. Chiropractors
3. Optometrists
4. Non-physician behavioral health providers (Including but not limited to: Psychologists, Social Workers, Licensed Professional Counselors, Marriage and Family Therapists/ Counselors, Nurse Practitioners working in behavioral health)
5. Nurse practitioners
6. Physician's assistants
7. Certified nurse midwives
8. Medical Genetics
9. Medical Therapists, for example, physical therapists, speech therapists, and occupational therapists, who are within the scope of credentialing (See Credentialing Policy #2)
10. For continued participation of assistant surgeons upon re-credentialing, if that physician certifies that he/ she: (1) will deliver services to HealthKeepers, Inc.'s Members in an assistant surgeon capacity only; and (2) has let his or her DEA registration voluntarily lapse because controlled substances requiring a DEA registration are not prescribed within the limited scope of that assistant surgeon's practice. However, re-credentialing is not allowed if the assistant surgeon's DEA registration is or was suspended, revoked, or surrendered for other reasons.
11. Radiologists practicing in an office setting
12. Pathologists practicing in an office setting
13. Licensed Genetic Counselors
14. Audiologists
15. Acupuncturists (non-MD/DO)
16. Registered Dietitians

Application and supporting documentation must not contain any omissions or falsifications, (including any additional information requested by HealthKeepers, Inc.), or in the presence of omission or falsifications must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

Education, training and certification must meet criteria for the specialty in which the applicant will treat HealthKeepers, Inc.'s Members including receipt of documentation of such education, training and certification from institutions acceptable to HealthKeepers, Inc., or in the absence of such must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

For MDs and DOs, current, in force board Certification (as defined by one of the following: ABMS, AOA, Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada) in the clinical discipline for which they are applying is viewed as meeting all education, training and certification requirements. As alternatives, MD's and DO's meeting any one of the following criteria will be viewed as meeting this education, training and certification requirement:

1. Previous board Certification (as defined by one of the following: ABMS, AOA, Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada) in the clinical Specialty or subspecialty for which they are applying which has now expired AND a minimum of 10 consecutive years of clinical practice.
2. Training which met the requirements in place at the time it was completed in the Specialty or subspecialty field prior to the availability of Board Certifications in that clinical Specialty or subspecialty.
3. Specialized practice expertise as evidenced by publication in nationally accepted Peer Review literature and/or recognized as a leader in the science of their Specialty AND a Faculty Appointment of Assistant Professor or higher at an Academic Medical Center and Teaching Professional in HealthKeepers, Inc.'s Network AND the applicant's professional activities are spent at that institution at least 50% of the time.

   Note: providers meeting one of the alternative criteria specified above will be viewed as meeting all HealthKeepers, Inc. education, training and certification criteria and will not be required to undergo additional review or individual presentation to the geographic Credentials Committee.
4. The individual is seeking provider specialty designation listing as a General practitioner and meets the criteria outlined in (a) and (b):
    a. Meets both of the following criteria:
        i. One year of training in the United States in a clinical discipline involving direct patient care in primary care, OB/Gyn or general surgery or any combination of these; AND
        ii. A minimum of 10 years of clinical practice experience; AND
    b. Meets one of the following criteria for network inclusion of a General Practitioner:
        i. Demonstrates significant access need or extenuating or special circumstances that warrant consideration; in other words, applicant has unique skills not otherwise available in network, for example, procedural, special language skills, or there is a need for this specialty

in this geographic area for access reasons: rural location and/or underserved population not served by other practitioners; AND

ii. Meets all credentialing criteria and processes outlined in Credentialing Policies.

HealthKeepers, Inc. reserves the right, in its reasonable discretion, to waive the board Certification or alternative requirement when HealthKeepers, Inc. determines that there are extenuating or special circumstances that warrant the waiver of such requirement.

Individuals will be granted five years – or in the case ABMS board certification, a period of time consistent with ABMS board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement. However, individuals no longer eligible for board Certification are not eligible for continued exception to this requirement unless the extenuating or special circumstances described in the above statement apply.

This board Certification requirement will not apply to MDs and DOs credentialed by the HealthKeepers, Inc. (or by an authorized delegated entity consistent with HealthKeepers, Inc.'s credentialing policy) and in good standing in the network as of the effective date of this policy unless they had been previously notified by HealthKeepers, Inc. of the need to become board certified. All practitioners will continue to undergo oversight through the standard re-credentialing and ongoing monitoring mechanism. Additionally, HealthKeepers, Inc.'s CC will assess unique situations where issues of limited access to care may dictate special consideration.

For DPMs (podiatrists) the applicant must be certified by either the American Board of Podiatric Medicine or the American Board of Foot and Ankle Surgery. As an alternative, podiatrists who were previously board certified by either the American Board of Podiatric Medicine or the American Board of Foot and Ankle Surgery which has now expired AND who have had a minimum of 10 consecutive years of clinical practice will be viewed as meeting this requirement. Podiatrists who meet the alternative requirement will not require additional review. HealthKeepers, Inc. reserves the right, in its reasonable discretion, to waive the board Certification requirement when HealthKeepers, Inc. determines: 1) That there are extenuating or special circumstances that warrant the waiver of such requirement AND 2) The Credentials Committee determines that there is no reasonable suspicion of future substandard professional conduct and/or competence.

Individuals with board certification from the American Board of Podiatric Medicine will be granted five years after the completion of their residency to meet this requirement. Individuals with board certification from the American Board of Foot and Ankle Surgery will be granted seven years after completion of their residency to meet this requirement.

However, individuals no longer eligible for board certification are not eligible for continued exception to this requirement.

This board Certification requirement will not apply to podiatrists credentialed by HealthKeepers, Inc. (or by an authorized delegated entity consistent with HealthKeepers, Inc.'s credentialing policy) and in good standing in the network as of the effective date of this policy, unless they had been previously notified by HealthKeepers, Inc. of the need to become board certified. All practitioners will continue to undergo oversight through the standard recredentialing and ongoing monitoring mechanism. Additionally, the HealthKeepers, Inc. CC will assess unique situations where issues of limited access to care may dictate special consideration.

For Oral and Maxillofacial Surgeons, the applicant must be certified by the American Board of Oral and Maxillofacial Surgery. As an alternative, Oral and Maxillofacial Surgeons who were previously board certified by the American Board of Oral and Maxillofacial Surgery which has now expired AND who have had a minimum of 10 consecutive years of clinical practice will be viewed as meeting this requirement. Oral and Maxillofacial Surgeons who meet the alternative requirement will not require additional review.

HealthKeepers, Inc. reserves the right, in its reasonable discretion, to waive the board Certification requirement when HealthKeepers, Inc. determines that there are extenuating or special circumstances that warrant the waiver of such requirement.

Individuals will be granted five years after completion of their residency or fellowship training program to meet the board Certification requirement. However, individuals no longer eligible for board Certification are not eligible for continued exception to this requirement.

This board Certification requirement will not apply to Oral and Maxillofacial Surgeons credentialed by HealthKeepers, Inc. (or by an authorized delegated entity consistent with HealthKeepers, Inc.'s credentialing policy) and in good standing in the network as of the effective date of this policy unless they had been previously notified by HealthKeepers, Inc. of the need to become board certified. All practitioners will continue to undergo oversight through the standard recredentialing and ongoing monitoring mechanism. Additionally, the HealthKeepers, Inc. CC will access unique situations where issues of limited access to care may dictate special consideration.

For MDs and DOs, the applicant must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO, or ACHA accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Some clinical disciplines may function exclusively in the outpatient setting, and HealthKeepers, Inc.'s

CC may at its discretion deem hospital privileges not relevant to these specialties. (See Attachment A.) Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. HealthKeepers, Inc. CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians is that there exists an appropriate referral arrangement with a network physician providing inpatient care.

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

Site visit and medical record review results, if applicable, must meet HealthKeepers, Inc. standards, or in the absence of meeting such standards must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

Complaints from Members and/or other Providers must be at levels deemed acceptable to HealthKeepers, Inc., or if such complaints exist and/or exceed such levels must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

Explanations for gaps in work history must be documented and meet HealthKeepers, Inc. standards, or in the presence of gaps that exceed such standards must not raise a reasonable suspicion of future substandard Professional Conduct and/or Competence.

History of professional liability suits, arbitrations or settlements must be within established HealthKeepers, Inc. standards, or in the presence of suits exceeding such standards, these suits, arbitrations or settlements must not raise a reasonable suspicion of future substandard Professional Conduct and/or Competence.

Performance indicators obtained during the credentialing, recredentialing or ongoing monitoring process that meet HealthKeepers, Inc. standards, or if not meeting such standards must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

No physical or mental impairment, (including chemical dependency and substance use disorder), that would affect the healthcare Practitioner's ability to practice within the scope of his or her license or pose a risk or imminent harm to Members. In the presence of a history of physical or mental impairment, the nature of the impairment and other information obtained during the credentialing or recredentialing or ongoing monitoring process must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

No history of disciplinary actions or sanctions against the applicant's license, DEA and/or CDS registration or any actions or sanctions of such nature as to raise a reasonable suspicion of future substandard Professional Conduct and/or Competence. Determination will be based upon the nature of the disciplinary action or sanction and other information obtained during the credentialing, re-credentialing and ongoing monitoring process. For applicants with current actions or sanctions, see above.

No history of disciplinary actions, sanctions, or revocations of privileges taken by hospitals and other healthcare facilities or entities, HMOs, PPOs, PHOs, etc. or, in the presence of such actions or sanctions, nothing in the nature of those to raise a reasonable suspicion of future substandard professional conduct and/or competence. Determination will be based upon the nature of the disciplinary action or sanction and other information obtained during the credentialing, re-credentialing or ongoing monitoring process.

No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence.

No other significant information, such as information related to boundary issues or sexual impropriety or illegal drug use which might indicate a reasonable suspicion of future substandard professional conduct and/or competence.

Policy 4.0.1: Behavioral Health Practitioner (non-physicians) – Education Criteria

HealthKeepers, Inc. has identified and developed minimum acceptable criteria for all practitioners who fall within the scope of its credentialing program. This policy specifically addresses only the education and training requirements of non- physician behavioral health practitioners. All relevant requirements detailed in this Credentialing Policy #4.0 including but not limited to: licensure, DEA (where applicable) work history (gaps and performance), disciplinary actions of any licensure agency, regulatory body, employer or managed care HealthKeepers, Inc., criminal actions, impairments and/or substance use disorder, site visits, liability experience, disclosure of adverse actions and Attestation during the application are applicable to these practitioners as well.

These criteria outlined in this policy do not apply to those Providers credentialed by the HealthKeepers, Inc. (or an authorized delegated entity consistent with HealthKeepers, Inc.'s credentialing policy) and in good standing as of the effective date of this policy. These practitioners will continue to undergo oversight through standard re-credentialing mechanisms.

Practitioners are reviewed for both initial credentialing, re-credentialing and ongoing monitoring in accordance with the following minimum standards for participation. These Credentialing criteria pertain to all practitioners of these Provider types. Practitioners will be credentialed according to the criteria applicable to their highest level of licensure. Practitioners failing to meet minimum criteria would be viewed as not eligible for participation. HealthKeepers, Inc. Credentials Committee (CC) may, however, assess unique access needs where issues of limited access to care may dictate special consideration. In these instances, the absence of any certification or other requirement must not raise a reasonable suspicion of future substandard conduct and competence.

Provider Type Eligibility Criteria – Education and Training (by provider type)

1. LICENSED CLINICAL SOCIAL WORKERS (LCSW) or other masters level social work license type based on state licensing regulations.
    a. Practitioner shall possess a master's or doctoral degree in social work. If a masters level degree does not meet criteria and the Provider obtained PhD training as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. In addition, a Doctor of Social Work will be viewed as acceptable licensure to practice independently.

2. LICENSED PROFESSIONAL COUNSELOR (LPC), MARRIAGE & FAMILY THERAPIST (MFT), Licensed Mental Health Counselor (LMHC) or other master level license type based on state licensing regulations.
    a. Practitioner shall possess a masters or doctoral degree in one of the following fields: counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental health field. Master or Doctoral degrees in Education are acceptable with one of the fields of study above. Master or Doctoral Degrees in Divinity, Masters in Biblical Counseling, or other primarily theological field of study, do not meet criteria as a related field of study.
    b. Practitioners with PhD training as a clinical psychologist can be reviewed. Practitioners with a Doctoral degree in one of the fields of study noted will be viewed as acceptable. Licensure to practice independently or in states without licensure or certification:
        i. Mental Health Counselors with a master's degree or higher: provider applicant must be a Certified Clinical Mental Health Counselor (CCMHC) as determined by the Clinical Academy of the National Board of Certified Counselors (NBCC) [proof of NBCC certification required] or meet all requirements to become a CCMHC [documentation of eligibility from NBCC required].
        ii. Marriage & Family Therapists with a master's degree or higher: Certified Confirmed eligibility or certification as a full clinical

member of the American Association for Marriage and Family Therapy (AAMFT), (documentation from AAMFT required).

3. Pastoral Counselors:
    a. Practitioner shall possess a master's or doctoral degree in a mental health discipline:
        i. Either licensed as another recognized behavioral health provider type (for example, MD/DO, PsyD, SW, RNCS, ARNP, and MFT, OR LPC) at the highest level of independent practice in the state where the practice is to occur, or licensed or certified as a pastoral counselor in the state where the practice is to occur; and
        ii. Be a fellow or diplomat member of the Association for Clinical Pastoral Education (ACPE) or meet all requirements to become a fellow or diplomat member of the ACPE [documentation of eligibility of ACPE required].

4. Clinical Nurse Specialist/Psychiatric & Mental Health Nurse Practitioner
    a. Practitioner shall possess a master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing.
    b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State Board of Registered Nursing, if applicable.
    c. Certification by the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA) in psychiatric nursing or the Pediatric Nursing Certification Board. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse practitioner or Family Psychiatric and Mental Health Nurse Practitioner.
    d. Valid, current, unrestricted Drug Enforcement Agency (DEA) Certificate, where applicable with appropriate supervision/consultation by a participating psychiatrists as applicable by the state licensing board. For those who possess a DEA Certificate, the appropriate State Controlled Substances Certificate if required.

5. Clinical Psychologists
    a. A valid state clinical psychologist license and, a Doctoral degree (PhD, PsyD, EdD) in clinical or counseling psychology or other applicable field of study.
    b. Master level therapists in good standing on the network, who upgrade their license to clinical psychologist as a result of further training will be allowed to continue in the network and will not be subject to the above education criteria.

6. Clinical Neuropsychologist
    a. Standard Criteria – Candidates must meet all the criteria for a clinical psychologist listed in section 4 above and be Board certified by either the American Board of Professional Neuropsychology (ABN) or American Board of Clinical Neuropsychology (ABCN) or in the absence of such certification does not raise a reasonable suspicion of future substandard conduct or competence.
    b. Alternative Criteria – Alternatively, a Provider credentialed by the National Register of Health Service Providers in Psychology with an area of expertise in neuropsychology may be considered, subject to review by the CC.
    c. Other Criteria – Clinical neuropsychologists who are neither board certified nor listed in the National Register will require individual CC review. These Providers must have appropriate training and/or experience in neuropsychology as evidence by one or more of the following:
        i. Training:
            1. Transcript of applicable pre-doctoral training; or
            2. Documentation of applicable formal 1 year post-doctoral training. (Participation in CEU training alone would not be considered adequate); or
            3. Letters from supervisors in clinical neuropsychology (including number of hours per week.
        ii. Experience:
            1. Minimum of 5 years' experience practicing neuropsychology at least 10 hours per week.

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

Virginia MH/SUD Licensures Which Meet Criteria

State	Acronym	Description
VA	PSY	Licensed Clinical Psychologist

LCSW	Licensed Clinical Social Worker
LMFT	Licensed Marriage & Family Therapist
LPC	Licensed Professional Counselor
CNS	Clinical Nurse Specialist

Policy 4.0.2: Credentialing of Nurse Practitioners, Certified Nurse Midwives and Physician's Assistants

The purpose of this policy is to address the credentialing of NPs, CNMs and PAs when an independent relationship exists between HealthKeepers, Inc. and the Practitioner, and such individual practitioner is listed individually in the network directory. Credentialing is not required if the NP, CNM, or PA provides care for Members only because Members are directed to a facility or contracted physician that employs the Practitioner.

General Criteria and Process:

HealthKeepers, Inc. has identified and developed minimum acceptable criteria for all practitioners who fall within the scope of its credentialing program. This Credentialing policy specifically addresses only the education and training requirements of Nurse Practitioners (NPs), Certified Nurse Midwives (CNMs) and Physician Assistants (PAs). All relevant requirements detailed in Credentialing Policy #4.0 including but not limited to: licensure, DEA (where applicable) work history (gaps and performance), disciplinary actions of any licensure agency, regulatory body, employer or managed care company, criminal actions, impairments and/or substance use disorder, site visits, liability experience, disclosure of adverse actions and attestation during the application are applicable to these practitioners as well. Also, all requirements for primary source verification outlined in Credentialing Policy are to be enforced. These include license, DEA (if applicable), education (if not performed by the state licensing body) and procurement of an NPDB report.

Ongoing Monitoring:

Midlevel practitioners added to the network will be subjected to the ongoing monitoring processes outlined in Credentialing Policy #12 and will be re-credentialed every three years as described in Credentialing Policy #9. The credentialing and re-credentialing process will occur as described in Credentialing Policies #4, through #9.

Completed Credentialing:

On successful completion of credentialing, the NPs/CNMs/PAs name will appear in a directory. The directory listing must clearly delineate the licensure type of the midlevel Practitioner.

Process, Requirements and Verification - Nurse Practitioners

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

B. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a Registered Nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the licensing agency does not verify highest level of education, the education will be primary source verified from the education institution.

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

D. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.

E. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
   1. Certification program of the American Nurse Credentialing Center, a subsidiary of the American Nursing Association, or
   2. American Academy of Nurse Practitioners Certification Program, or
   3. National Certification Corporation, or
   4. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (**Note:** CPN – certified pediatric nurse is not a nurse practitioner) or
   5. Oncology Nursing Certification Corporation (ONCC) -Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY
   6. American Association of Critical Care Nurses ACNPC – Adult Care Nurse Practitioner; ACNPC-AG – Adult Gerontology Acute Care

   If the applicant is not certified or if his/her certification has expired, the application will be classified as a Level II and submitted for individual review by the geographic Credentialing Committee pursuant to the board certification or alternative requirements set forth for MDs and DOs in Credentialing Policy #4.0.

This certification must be active. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by HealthKeepers, Inc. is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy and submitted for individual review by the Credentialing Committee pursuant to the board certification or alternative requirements set forth for MDs and DOs in Credentialing Policy #4.0.

F. If the NP has hospital privileges, they must have hospital privileges at a CIHQ,TJC, NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the NP will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
G. The NP applicant will undergo the standard credentialing processes outlined in Credentialing Policies. NPs are subject to all the requirements outlined in these policies including (but not limited to): the requirement for Committee review of Level II files for failure to meet predetermined criteria, recredentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
H. Upon completion of the credentialing process, the NP may be listed in HealthKeepers, Inc.'s directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process discussed in Credentialing Policy.
I. NPs will be clearly identified as such:
    1. On the credentialing file,
    2. At presentation to the Credentialing Committee, and
    3. On notification to Network Services and to the provider database.

Process, Requirements and Verifications - Certified Nurse Midwives

A. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training and board certification.

B. The required educational/training will be at a minimum that required for licensure as a Registered Nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with Credentialing Policy

C. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force

adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.

D. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.

E. All CNM applicants will be certified by either:

   1. The National Certification Corporation for Ob/Gyn and Neonatal Nursing, or
   2. The American Midwifery Certification Board, previously known as the American College of Nurse Midwifes.

   This certification must be active. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy and submitted for individual review by the Credentialing Committee.

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

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

H. Upon completion of the credentialing process, the CNM may be listed in HealthKeepers, Inc. directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process discussed in Credentialing Policy.

I. CNMs will be clearly identified as such:
   1. On the credentialing file,
   2. At presentation to the Credentialing Committee, and
   3. On notification to Network Services and to the provider database.

Process, Requirements and Verifications – Physician Assistants (PA)

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

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

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

C. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.

D. All PA applicants will be certified by the National Commission on Certification of Physician's Assistants.
This certification must be active. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy and submitted for individual review by the Credentialing Committee.

E. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.

F. The PA applicant will undergo the standard credentialing process outlined in Credentialing Policies. PAs are subject to all the requirements described in these policies including (but not limited to): Committee review of Level II files failing to meet predetermined criteria, recredentialing every three years, and continuous sanction and performance monitoring upon participation in the network.

G. Upon completion of the credentialing process, the PA may be listed in HealthKeepers, Inc. directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process discussed in Credentialing Policy.

H. PAs will be clearly identified such:

1. On the credentialing file,
2. At presentation to the Credentialing Committee, and
3. On notification to Network Services and to the provider database.

Policy 4.1: Professional Competence and Conduct Criteria – Health Delivery Organizations

A. Health Delivery Organizations (HDOs) that participate in HealthKeepers, Inc.'s provider network(s) and are within the scope of the credentialing program must meet appropriate standards of professional conduct and competence as reviewed and determined by HealthKeepers, Inc.'s National Credentials Committee (NCC). HDOs within scope of credentialing policy are listed in Credentialing Policy #2.

B. Each HDO applying for initial credentialing or re-credentialing must satisfy the applicable eligibility criteria regarding professional conduct and competence to participate in one or more of HealthKeepers, Inc.'s programs or provider network(s). Eligibility criteria can be separated into two categories: (1) criteria not subject to committee review (must be met); and (2) criteria subject to appropriate standards of professional conduct and competence as reviewed and determined by a peer committee. The latter must be reviewed and approved by the geographic Credentials Committee (CC). Required elements and other eligibility criteria for HDO's are described in detail in "Procedures" (below).

C. The NCC determines the HDO types defined within scope of HealthKeepers, Inc.'s program, as established by, but not limited to: perceived risk to membership and volume of services rendered.

1. **Eligibility Criteria Not Subject to Committee Review** – all HDOs within the scope of HealthKeepers, Inc. Credentialing program applying for <u>initial</u> or <u>continued</u> participation in HealthKeepers, Inc.'s programs or provider network(s) <u>must</u> meet the following criteria in order to be considered for participation:
   a. Possess a current, valid, unencumbered, unrestricted, and non-probationary professional license in the state(s) where it provides services to HealthKeepers, Inc.'s Members, if such license is applicable. **Note:** If, once an HDO participates in HealthKeepers, Inc.'s programs or provider network(s), a HDO's license become non-current, invalid, encumbered, restricted, or probationary, at the time of identification, information will be brought to HealthKeepers, Inc.'s peer review committee for consideration regarding the HDO's continued participation in HealthKeepers, Inc.'s credentialed network. Note: In jurisdictions where the licensing entity issues temporary, conditional, or provisional licenses ("provisional license") to new HDO applicants or to HDO applicants fully licensed but adding new services, the Company may, at its discretion accept the provisional license when

issued in accordance with all applicable state requirements. In instances where a provisional license is accepted, the Company will also establish a timeframe in which a permanent license is required. In the event a provisional license is issued due to an encumbrance, probation, or other restrictive action against the licensee, the provisional license will be viewed as not meeting criteria.

b. Must not be currently sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the Federal Employees Health Benefits Program (FEHB). **Note:** If, once an HDO participates in HealthKeepers, Inc.'s programs or provider network(s), exclusion from Medicare, Medicaid or FEHB occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider network(s) as well as HealthKeepers, Inc.'s other credentialed provider network(s).
c. Must be in good standing with any other applicable state or federal regulatory body as defined in Credentialing Policy.

Criteria subject to appropriate standards of professional conduct and competence as reviewed and determined by a peer committee – all HDOs within the scope of HealthKeepers, Inc.'s Credentialing Program applying for initial or continued participation in HealthKeepers, Inc.'s programs or provider network(s) should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the geographic Credentials Committee (CC):

Note: If an applicant for initial participation or continued participation in HealthKeepers, Inc.'s programs or networks does not meet one or more of the following criteria, its history must not raise a reasonable suspicion of future substandard professional performance. The CC will consider the applicant's history on an individual basis pursuant to Credentialing Policies #8, and 9. This will be regarded as a Level II review if performed during credentialing or re-credentialing, or an Off Cycle, Level III review if information is received and reviewed between the normal re-credentialing cycle (see Credentialing Policy #12).

i. Application and supporting documentation must not contain any material omissions or falsifications, including any additional information requested by HealthKeepers, Inc.
ii. Complaints received from Members and/or other providers may be reviewed for compliance with HealthKeepers, Inc. standards.
iii. Performance indicators obtained during the credentialing, re-credentialing or ongoing monitoring process, if applicable, must meet HealthKeepers, Inc. standards.
iv. No indictments or convictions, or pleadings of guilty or no contest to, a felony or any offense involving fraud, criminal activities, abuse or

neglect nor evidence of such conviction or pleadings by the principals of the facility.

v. Any history of disciplinary actions or investigations, including termination, warnings, or notices of potential poor performance related to the HDO's license or accreditation must be reviewed and must not raise reasonable suspicion of future substandard performance or harm to Members. Determination will be based upon the nature of the disciplinary action or sanction and other information obtained during the credentialing, re-credentialing or sanction monitoring process. For HDOs with current actions or sanctions, see Section.1.b above.

vi. Acceptable accreditation from a recognized entity exists or in the absence of this accreditation meets the following criteria:
    a. Must have an access needs waiver submitted on their behalf and meet the following criteria:
        i. Be confirmed to be delivering services in a designated rural area (based on US Census Bureau); or
        ii. Submit a copy of the Medicare or state agency survey report performed within the past 36 months to be retained in the provider's file; and
            1. Have no deficiencies noted on Medicare or state oversight review which would adversely affect quality of care or patient safety (see Attachment B for SNFs: scope and severity of identified deficiencies cannot be rated "E, F, G, H, I, J, K or L."); and
            2. Have the Medicare or state agency survey approved after individual review to validate compliance with HealthKeepers, Inc. standards by the Credentials Committee; or
            3. Undergo or have undergone within the prior 36 months a site visit survey and receive a passing score by a designated independent external entity (DIEE) using that external entity's previously established and NCC approved criteria.
            4. If a provider has satellite facilities that follow the same policies and procedures as the provider, the organization may limit site visits to a main facility.

Initial HDO Credentialing Process and Standards

i. New HDO applicants submit a standardized application to HealthKeepers, Inc. for review.

ii. Applicants who meet HealthKeepers, Inc. initial eligibility criteria will undergo professional conduct and competence review.

iii. As part of eligibility criteria accreditation appropriate for HDO type should be verified per below.
iv. Accredited HDO's or Medicare certified SNFs meeting all criteria will be viewed as Level I providers and may be approved by the chair/vice-chair of the CC or medical director designee..

HDO Type and HealthKeepers, Inc. Approved Accrediting Agent(s)

Medical Facilities

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Acute Care Hospital	CIQH, TCT, ACHC, DNV/NIAHO, TJC
Ambulatory Surgical Centers	TJC,ACHC, AAPSF, AAAHC, QUAD A, IMQ
Birthing Center	AAAHC, CABC, TJC
Home Health Care Agencies (HHA)	ACHC, TCT , DNV/NIAHO, TJC, CHAP
Home Infusion Therapy (HIT)	ACHC, TCT, TJC, CHAP
Skilled Nursing Facilities/Nursing Homes	TJC, CARF
Durable Medical Equipment Providers	TJT,CHAP,TCT, ACHC, BOC, HQAA

Behavioral Health

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Care Hospital–Psychiatric Disorders	DNV/NIAHO, TJC, ACHC, TCT
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, ACHC, TJC
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Use Disorder	ACHC, DNV/NIAHO, TJC, COA, CARF

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinic	ACHC, TJC, CARF, COA, CHAP
Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Use Disorder	DNV/NIAHO, TJC, CARF
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Use Disorder	DNV/NIAHO, TJC, ACHC, CARF, COA

Rehabilitation

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

Policy 5: Initial Application

I. Health Care Practitioners

Each practitioner applying for initial participation in HealthKeepers, Inc. programs or networks must complete and submit HealthKeepers, Inc.'s applicable credentialing application along with all required supporting documentation. The application process may occur either electronically or on paper.

1. Faxed, digital, electronic, scanned or photocopied signatures are acceptable. Signature stamps are not acceptable unless the practitioner is physically impaired. The organization must document the disability in the Practitioner's file if the practitioner uses a signature stamp. Pencils are not an acceptable writing instrument for credentialing documentation. Written documentation must be non-erasable ink.
2. The application materials sent by HealthKeepers, Inc. include, at a minimum the following:

    a. Cover letter or other explanatory information;

b. Credentialing application; and

c. Attestation form

3. A practitioner will be notified that he or she has the right to review information submitted to support their credentialing application. This right includes access to information obtained from any outside source with the exception of references, recommendations or other peer review protected information.
4. In the event that credentialing information cannot be verified or there is a discrepancy in the credentialing information obtained, the credentialing staff will contact the practitioner within thirty (30) calendar days of the identification of the issue. This communication will specifically notify the practitioner of their right to correct erroneous information or provide additional details regarding the issue in question. This notification will also include the specific process for the submission of this additional information and to whom the information should be sent. Depending upon the nature of the issue in question, this communication may occur verbally or in writing. All communication on the issue(s) in question, including either copies of the correspondence or a detailed record of phone calls, will be clearly documented in the Practitioner's credentials file. The provider will be given no less than 14 calendar days in which to provide additional information.
5. Responses received from practitioners to requests for clarification will be documented in the credentials file. Oversight of this process for additional information or clarification will be the responsibility of the manager of the credentialing unit.
6. HealthKeepers, Inc. may request and shall accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The Credentials Committee will review this information and the rationale presented by the applicant to determine if either a material omission has occurred or if other credentialing criteria are met.
7. Upon request, applicant will be provided with the status of his or her credentialing application. Written notification of this right may be included in a variety of communications from HealthKeepers, Inc. These include: the provider web site or the provider manual. This notification includes the information needed to make this request. When such requests are received, providers will be notified whether the application has been received, how far in the process it has progressed and a reasonable date for completion and notification. All such requests will be responded to verbally unless the provider requests a written response.
8. In completing the application, each applicant must disclose the existence of, and provide explanations for, the following:
   a. Instances in which the applicant has been the subject of any disciplinary review or action by any state licensing board or is aware that an investigation is pending that may lead to disciplinary action;

b. Malpractice history, including pending malpractice suits and payments made by any malpractice carrier on the Practitioner’s behalf for any professional liability claim, suit, or judgment.
c. Involuntary termination by an employer or healthcare organization or resignation with knowledge of a pending investigation, or is aware that an investigation is pending that may lead to disciplinary action;
d. Revocation, suspension or limitation of privileges at a participating hospital, or resignation with knowledge of a pending investigation or any action which might lead to revocation, suspension or limitation of privileges;
e. Current illegal drug use or use of any chemical substances that would in any way impair or limit the ability to practice medicine and/or perform job functions with reasonable skill and safety;
f. Convictions, whether as a result of a guilty plea, a plea of no contest or a verdict of guilty, of a felony, any offense involving or fraud, or any offense related to practice of healing arts, or is aware that an investigation is pending that may lead to such action;
g. Instances in which the practitioner has been sanctioned or debarred from Medicare, Medicaid or FEHB programs or is aware that an investigation is pending that may lead to such action;
h. Revocations, suspensions or surrenders of the Practitioner's Drug Enforcement Agency (DEA), or Controlled Dangerous Substances (CDS) certificates or licenses, or is aware that an investigation is pending that may lead to disciplinary action if applicable;
i. Physical or mental health reasons which would limit the Practitioner's ability to provide services to a patient;
j. Additional information requested by HealthKeepers, Inc. to explain or provide details regarding responses obtained on the credentialing application.

9. All practitioners must sign and date an attestation statement that includes, but is not limited to:
   a. Reasons for any inability to perform the essential functions of the position, with or without accommodation;
   b. Lack of present illegal drug use;
   c. History of licensing board action or felony convictions;
   d. History of loss or limitation of privileges or disciplinary activity;
   e. Current malpractice insurance coverage;
   f. The correctness and completeness of the application;
   g. Permission to release information as needed to complete the credentialing process.
10. Each practitioner must submit, along with the application, at a minimum the following:
   a. Curriculum vitae, resume or work history if work history is not included on the application.

b. The application attestation including work history verification must be dated and verified within 180 calendar days prior to the Credentials Committee decision.
c. The file will go through a thorough review before it is presented to the Credentials Committee to assess completeness in data. All of the required information must be current when presented to the geographic Credentials Committee (CC) and must be verified within the required time frame of either 180 or 120 calendar day period prior to the CC making its credentialing recommendations or as otherwise required by applicable accreditation standards.

II. Health Delivery Organizations (HDO):
1. Each HDO applying for initial participation in HealthKeepers, Inc.'s programs or provider network(s) must complete and submit HealthKeepers, Inc.'s applicable credentialing application along with all required supporting documentation.
2. The application materials sent by HealthKeepers, Inc. include, at a minimum, the following:
   a. Cover letter or other explanatory information;
   b. Credentialing application;
   c. Attestation form.
3. In completing the application, each HDO must disclose the existence of, and provide explanations for, the following:
   a. Instances in which the HDO has been the subject of any disciplinary review or action by any state licensing board or any federal agencies or is aware of a pending investigation that may lead to such action;
   b. Instances in which the HDO's malpractice insurance has been terminated, denied, suspended or limited or is aware of a pending investigation that may lead to such action;
   c. Convictions, whether as a result of a guilty plea, a plea of no contest or a verdict of guilty, of a felony, any offense involving fraud, or any offense related to practice of healing arts during the past five (5) years of an HDO principal officer or is aware of a pending investigation that may lead to such action;
   d. Instances in which the facility has been sanctioned or debarred from Medicare, Medicaid or FEHB programs or is aware of a pending investigation that may lead to such action;
   e. Additional information requested by HealthKeepers, Inc. to explain or provide details regarding responses obtained on the credentialing application or additional issues regarding issues of professional competence and conduct.
4. All HDO applications must include a signed and dated attestation statement that includes, but is not limited to:
   a. History of loss of license and felony convictions;

    b. Current malpractice insurance coverage; and
    c. The correctness and completeness of the application.
5. Each HDO must submit, along with the application, at a minimum the following:
    a. Medicare certification, if applicable;
    b. Recognized accrediting organization certification or Medicare or state site survey results.
6. Upon request, HDO's will be provided with the status of its credentialing application.
7. HealthKeepers, Inc. may request and shall accept additional information from the HDO to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC will review this information and the rationale presented by the applicant to determine if either a material omission has occurred or if other credentialing criteria are met.
8. In the event that credentialing information cannot be verified or there is a discrepancy in the credentialing information obtained, the credentialing staff will contact the HDO to assist in obtaining the information or to provide detailed information regarding the issue in question. All documentation on the issue(s) in question, including a record of phone calls, will be included in the HDO's credentials file.
9. The file will go through a review before it is presented to the Credentials Committee to ensure completeness in data. All of the required information must be current when presented to the CC and must be verified within the 120 calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

Non-discrimination Policy:

HealthKeepers Inc. will not discriminate against any applicant for participation in its programs or provider network(s) on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. HealthKeepers Inc. is required to include fields for the collection of practitioner race, ethnicity, and language on the application. However, HealthKeepers Inc. does not use such reported to discriminate against a practitioner, and the application includes a statement indicating the provision of such information is optional. Additionally, HealthKeepers Inc. will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Determinations as to which practitioners and providers require additional individual review by the Credentials Committee are made according to predetermined criteria related to professional conduct and competence. Credentials Committee decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. HealthKeepers Inc. will review denials and terms for consistency and lack of discrimination annually to identify discriminatory practices in the selection of practitioners. These reviews are documented in a report summary format by reason for

the denial or term for initial denials, recredentialing, terminations, and off-cycle terminations. The reasons for denial or term include: not board certified, license/board action, malpractice, education/training, hospital privileges, criminal conviction, DEA, hospital action, insurance, work history gap, and federal sanctions. In addition, annually audits of practitioner complaints about credentialing shall be reviewed for evidence of alleged discrimination. Should discriminatory practices be identified through annual review or through other means, HealthKeepers Inc. will take appropriate action(s) to track and eliminate those practices.

In further effort to prevent and take proactive steps to protect against discrimination in the credentialing process, adherence to HealthKeepers, Inc. nondiscrimination policy is reinforced at Credentials Committee meetings via inclusion of the following statement on each agenda:
As a Committee member, I will not discriminate against any potential candidate on the basis of race, gender, color, religion, national origin, ancestry, sexual orientation, age, veteran, marital status, or healthcare providers that serve high risk populations or those who specialize in the treatment of costly conditions. Other than gender and language capabilities, which are provided to the members to meet their needs and preferences, this information is not required in the credentialing or recredentialing process. Credentials committee members' decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process.

Review and Determination:

All applications for initial participation in HealthKeepers, Inc.'s programs or provider network(s) shall be reviewed and a determination made by the Credentials Committee.

Policy 6 (Skipped Intentionally)

Policy 7: Site Visits

A. HealthKeepers, Inc. will establish specific criteria and threshold standards related to sites where network practitioners provide medical care for HealthKeepers, Inc.'s Members. These standards will address at a minimum the following:
   1. Physical Accessibility for individuals with special needs
   2. Physical Appearance
   3. Adequacy and appearance of waiting room space
   4. Adequacy of examination room space
   5. Availability of appointments
   6. Adequacy of medical/treatment record keeping

B. Upon receipt of a Member complaint related to any of the items listed 1-4 above, HealthKeepers, Inc. will assess the complaint(s) using the established criteria. When the threshold is exceeded, an associate or agent of HealthKeepers, Inc. will perform a site visit within 60 days from the date the Member complaint was received.

Procedures

A. Site Visit Evaluations
    1. Site Evaluation Meeting Standards will be documented as such and practitioner notified. No further actions are required.
    2. Site Evaluations NOT Meeting Threshold Criteria
        a. When a site visit fails to meet standards, the practitioner office will be notified of the details of the deficiencies and a specific, mutually agreeable, time frame for remediation will be established.
        b. Corrective action may consist of:
            i. Submission of a formal written corrective action plan, or
            ii. For isolated and easily corrected deficiencies, documentation of correction may be provided as evidence of remediation.
    3. Correction of any deficiencies noted on a site visit will be completed according to a mutually agreed upon timeframe.
    4. All site evaluations not meeting threshold will be reviewed at least every six months for progress towards goal.
    5. The follow up visit will specifically address the deficiencies noted on the earlier review.
    6. When the corrective actions are complete and the deficiencies corrected, a follow-up visit will be performed to document that the deficiencies have been corrected. No further action is required.
    7. When a practitioner fails to correct deficiencies, the issue will be referred to the appropriate quality review committee for additional review and action. If the quality review committee notes a site visit issue that it believes is of sufficient concern for consideration for termination of the Practitioner(s), it will be referred to the Credentialing Committee.
    8. Member complaints regarding site visit issues related to office accessibility and appearance, or waiting room or exam room issues will be summarized every six months. This summary will be reviewed by appropriate quality review committee.
B. Recurrent Complaints About the Same Criteria or Office Site
        1. If the complaint threshold is met again for the same or different office site criteria, another office site visit is required. The same procedure listed under section “I. Site Visit Evaluation” would be followed.

Policy 8 (Skipped Intentionally)

Policy 9: Recredentialing

All applicable practitioners and HDOs in HealthKeepers, Inc.'s network are required to be recredentialed at least every (3) three years, unless otherwise required by contract or state regulations.

Health Care Practitioners:

If appropriate credentialing data to complete the recredentialing process is not available from the Council for Affordable Quality Healthcare ("CAQH") ProView system, a recredentialing packet or an electronic notification will be sent to the practitioner at predetermined time prior to the recredentialing date. When the necessary information is available from the Council for Affordable Quality Healthcare ("CAQH") ProView system will be utilized. If after appropriate efforts to facilitate response the practitioner does not respond in a timely manner the practitioner may be administratively terminated.

Each practitioner applying for continued participation in HealthKeepers, Inc.'s programs or networks must complete and submit HealthKeepers, Inc.'s applicable recredentialing application along with all required supporting documentation.

The application materials include, at a minimum, the following:

a. Explanatory Information
b. Application
c. Attestation form

The practitioner will be notified of his/her right to review information submitted in support of the application. This right includes access to information obtained from any outside source with the exception of references, recommendations or other Peer Review protected information. In the event that recredentialing information obtained through other sources varies substantially from that provided by the Practitioner, HealthKeepers, Inc. credentialing personnel will notify the practitioner of this discrepancy and of their right to correct errors or provide further information regarding the apparent discrepancy. This notification may occur in writing or verbally, as circumstances warrant, but will occur within 30 calendar days of the identification of the discrepancy. At the time of this communication the practitioner will also be notified of the specific mechanism by which to correct errors or to provide detailed information as well as to who this information is to be submitted. Complete documentation of this notification including either copies of the correspondence or detailed information regarding phone calls will be maintained in the credentialing file. The practitioner will be allowed no less than 14 calendar days to provide the requested information. All additional information received will be documented in the credentials file.

Upon request, practitioners will be provided with the status of his or her recredentialing application. Written notification of this right is provided via the same mechanism

described in the Credentialing Policy. This notification includes the information needed to make this request. When such requests are received, Providers will be notified whether the application has been received, how far in the process it has progressed and a reasonable date for completion and notification. All such requests will be responded to verbally unless the Provider requests a written response.

HealthKeepers, Inc. may request and shall accept additional information from the practitioner to correct incomplete, inaccurate, or conflicting credentialing information. The credentials committee will review this information and the rationale presented and determines if either a material omission has occurred or if other recredentialing criteria are met.

In completing the application, each practitioner must disclose the existence of, and provide explanations for any activity since their last credentialing:
instances in which the practitioner has been the subject of any disciplinary review or action by any state licensing board or is aware that an investigation is pending that may lead to disciplinary action;

A. malpractice history, including pending malpractice suits;
B. instances in which the Practitioner’s malpractice insurance has been terminated, denied, suspended or limited or is aware that such action is pending;
C. payments made by any malpractice carrier on the Practitioner’s behalf for any professional liability claim, suit or judgment(s);
D. involuntary termination by an employer or healthcare organization, or is aware of a pending investigation that may lead to such action;
E. revocation, suspension or limitation of privileges at a participating hospital, or is aware of a pending investigation that may lead to such action;
F. current illegal drug use or use of any chemical substances that would in any way impair or limit the ability to practice medicine and/or perform job functions with reasonable skill and safety;
G. convictions, whether as a result of a guilty plea, a plea of no contest or a verdict of guilty, of a felony, any offense involving fraud, or any offense related to practice of healing arts, or is aware of a pending investigation that may lead to such action;
H. instances in which the practitioner has been excluded, sanctioned or debarred from Medicare, Medicaid or FEHBP programs, or is aware of a pending investigation that may lead to such action;
I. revocations, suspensions (or revocations) of the Practitioner's Drug Enforcement Agency (DEA), or Controlled Dangerous Substances (CDS) certificates or licenses, if applicable, or is aware of a pending investigation that may lead to such action;
J. physical or mental health reasons which would limit the Practitioner's ability to provide services to a patient; and
K. additional information such as information regarding boundary issues or sexual misconduct or illegal drug use requested by HealthKeepers, Inc. to explain or provide details regarding responses obtained on the credentialing application.

All practitioners must sign and date an Attestation statement. This Attestation may occur electronically or on paper and contains information that includes, but is not limited to:

1. Reasons for any inability to perform the essential functions of the position, with or without accommodation;
2. Lack of present illegal drug use
3. History of licensing board action or felony convictions
4. History of loss or limitation of privileges or disciplinary activity
5. Current malpractice insurance coverage
6. Attestation to the correctness and completeness of the application.
7. Consent to obtain information necessary for recredentialing

Each practitioner must submit, along with the application, at a minimum the following:

1. Board Certification status information (if applicable)

At the minimum the following information will be verified:

1. A valid state license to practice, and information regarding any sanctions, probations or other actions taken against any state license
2. Copy of a valid DEA and CDS certificate or verification through the National Technical Services Database (if applicable)
3. Board Certification (only if the Practitioner's board Certification has expired or is new since the last credentialing. Not applicable for chiropractors.)
4. History of professional liability history
5. National Practitioner Data Bank Information
6. Hospital privileges or Attestation to participating hospitals (if applicable)
7. Office of the Inspector General activity
8. Medicare/Medicaid sanction and exclusions activity
9. Internal information gathered during Ongoing Monitoring such as data from grievance and appeals, complaints, results of quality reviews, utilization management reviews and satisfaction surveys, as applicable.

Health Delivery Organizations (HDOs):

Each HDO applying for continuing participation in HealthKeepers, Inc.'s programs or networks will be reassessed on at least a three year cycle.
In performing re-credentialing review all HDOs will be evaluated for the status of their licensure and accreditation. HDOs which have appropriate state licensure without sanction, probation or other adverse action and which have maintained accreditation by an agency recognized by HealthKeepers, Inc. (see Credentialing Policy #4.1) will be viewed as meeting all criteria and will be classified in the re-credentialing process as Level I providers (See Credentialing Policy #4.1). Level I HDO's may be approved by the chair/vice-chair of the CC or a medical director designee as noted in Credentialing Policy #3.

Non-accredited HDOs: in the absence of this accreditation, HDOs must meet exception criteria as outlined in Credentialing Policy #4.1 (Professional Competence and Conduct Criteria - Health Delivery Organizations).

Upon request, HDOs will be provided with the status of its credentialing application. HealthKeepers, Inc. may request and shall accept additional information from the HDO to correct incomplete, inaccurate or conflicting credentialing information. The credentials committee will review this information along with the rationale presented, and determine if either a material omission has occurred or if credentialing criteria are met.

Non-discrimination Policy

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

In further effort to prevent and take proactive steps to protect against discrimination in the re-credentialing process, adherence to HealthKeepers, Inc.’s nondiscrimination policy is reinforced at Credentials Committee meetings via inclusion of the following statement on each agenda:

As a Committee member, I will not discriminate against any potential candidate on the basis of race, gender, color, religion, national origin, ancestry, sexual orientation, age, veteran, marital status, or healthcare providers that serve high risk populations or those who specialize in the treatment of costly conditions. Other than gender and language capabilities, which are provided to the members to meet their needs and preferences, this information is not required in the recredentialing process. Credentials committee members' decisions are based on issues of professional conduct and competence as reported and verified through the re-credentialing process.

Policy 10: Termination and Immediate Termination

Practitioner's or HDO's participation in HealthKeepers, Inc.'s programs or networks may be terminated for any lawful reason, including but not limited to failure to meet standard eligibility criteria due to a lapse in basic predetermined professional conduct and competence credentialing criteria, involving licensure (revocation, suspension or surrender), required medical staff Membership, privileges, Certification or accreditation or sanction, debarment or exclusion from the Medicare, Medicaid or FEHB programs. Additionally, a Practitioner's or HDO's participation in HealthKeepers, Inc.'s programs or networks may be reassessed when HealthKeepers, Inc. receives information relative to professional conduct and competence including but not limited to a history of professional disciplinary actions, malpractice history, unprofessional conduct, moral turpitude, criminal convictions, reportable malpractice actions, loss or surcharge of malpractice insurance, or other events which affects or could adversely affect the health or welfare of a patient reasonably calling into question the Practitioner's or HDO's ability, capacity or intent to deliver efficient, quality patient care.

Actions adverse to a Practitioner's or HDO's continued participation in HealthKeepers, Inc.'s programs or networks which are not based on concerns related to professional qualifications are not addressed in this policy, except to the extent that such practices may have been determined to be unprofessional conduct and/or competence by HealthKeepers, Inc. Credentials Committee (CC). Examples of such actions not addressed in this policy are those related to network over capacity, or unsatisfactory business or billing practices. These are viewed as Administrative Actions.

Additionally, whenever a Practitioner's or HDO's conduct requires that immediate action be taken as continued participation in HealthKeepers, Inc.'s programs or provider_network(s) poses an imminent risk of harm to HealthKeepers, Inc.'s Members or if the Practitioner's license is suspended, probated or revoked, or a Provider has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, a process for immediate termination may be invoked.

Procedures

A. Terminations:

If upon re-credentialing review or off-cycle review, the CC renders a decision of suspension or termination for cause, the practitioner (or HDO) shall be so notified and advised of the right to appeal the determination. If the practitioner (or HDO) invokes the right to appeal, the Provider (or HDO) shall be provided an appeal in accordance with procedure set forth in Credentialing Policy Appeals. If the practitioner (or HDO) does not invoke the right to an appeal or the appeals process upholds the CC's decision to suspend, terminate, the practitioner (or HDO), along with appropriate internal HealthKeepers, Inc. departments, shall be notified of the effective date of the termination.

B. Immediate Termination:

1. Routine issues regarding a Practitioner's or HDO's professional conduct and/or competence shall be reviewed by the chair/vice-chair of the CC and referred to the CC for review. However, when HealthKeepers, Inc. receives information that a Practitioner's or HDO's continued participation in HealthKeepers, Inc.'s programs or provider network(s) may pose some potential risk to the health or welfare of one or more of HealthKeepers, Inc.'s Members or may potentially result in imminent danger to the health or welfare of one or more of HealthKeepers, Inc.'s Members due to specific issues of professional conduct and competence or a Provider has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, a process for immediate termination exists. In such instances, the chair/vice-chair of the CC and/or HealthKeepers, Inc. Medical Director or designee, after consultation with legal counsel, may terminate the Practitioner's participation in HealthKeepers, Inc.'s programs or provider network(s), effective immediately and provide notice to the practitioner or HDO. The investigation in support of such immediate termination may occur in an expedited timeframe. The practitioner or HDO shall be sent a written statement of this decision.
2. When the process for Immediate Termination is invoked, the action will be reported and reviewed and the next scheduled meeting of the Credentials Committee.
3. The practitioner (or HDO) may have the right to appeal, but participation may not be reinstated during the appeals process. If a decision to immediately terminate a practitioner (or HDO) is overturned on review or appeal, the practitioner (or HDO) shall be reinstated, and will not lose any of the protections to which practitioner (or HDO) had been entitled before the Immediate Termination. These include the exemption from criteria such as Certification or accreditation based on their prior participation.

C. Reporting:

HealthKeepers, Inc. shall comply with the reporting requirements of state licensing agencies and the National Practitioner Data Bank, the Federal Healthcare Quality Improvement Act (Title IV of Public Law 99-660) regarding

adverse credentialing and Peer Review actions, and/or other organizations as required by law.

Policy 11: Report of Adverse Actions

The credentialing staff will comply with all state and federal regulations in regard to the reporting of adverse determinations relating to professional conduct and competence. These reports will be made to the appropriate, legally designated agencies.

In the event that the procedures set forth in this Policy for reporting reportable adverse actions conflict with the process set forth in the current National Practitioner Data Bank (NPDB) Guidebook, the process set forth in the NPDB Guidebook will govern.

Procedures

A. Reporting

1. When a Professional Review Action is taken by HealthKeepers, Inc. with respect to a professional Provider's participation in one or more HealthKeepers, Inc. networks, HealthKeepers, Inc. may have an obligation to report such to the NPDB. Once HealthKeepers, Inc. receives a verification of the NPDB report, the verification report will be sent to the state licensing board.

   NPDB. Professional Review Actions of providers shall be reported electronically to NPDB as applicable and in writing to the applicable state licensing board, if required, following that state's requirements for filing a written report. (Institutional Providers are not subject to this reporting requirement). The report shall be filed with the state licensing board if required, and NPDB as applicable, no later than 15 days of the earlier of (a) the effective date of the providers immediate contract termination due to imminent danger to an individual's health and safety; or (b) the exhaustion of the providers appeal rights and the date the adverse Professional Review Action has been made final. Notwithstanding the foregoing, HealthKeepers, Inc. may report the matter to other appropriate governmental or private organizations, provided such reporting is approved in advance by the Legal Department in conjunction with consultation with the Special Investigations Unit.
2. If HealthKeepers, Inc., in its discretion, accepts a Provider's voluntary resignation or without cause termination in lieu of HealthKeepers, Inc.'s termination of the Provider for any reason that would otherwise lead to a Professional Review Action then HealthKeepers, Inc. may have a reporting obligation despite the fact that a Formal Appeal was not offered. Thus, the Legal Department must be consulted prior to any without cause terminations or prior to accepting any voluntary resignations for reasons other than retirement, the Provider moving from the area, or other reason that is not truly for cause.

3. Any report made under this Policy and Procedure shall only include the minimum necessary information to fulfill HealthKeepers, Inc.'s reporting obligation.
4. HealthKeepers, Inc.'s failure to report as required under applicable laws can result in fines and Civil Monetary Penalties against HealthKeepers, Inc.
5. HealthKeepers, Inc. shall protect from disclosure any information that it reports to or receives in a report from NPDB or state licensing board.
6. All Professional Review Actions must be reviewed by the Legal Department in advance of any report to the state licensing board or NPDB.
7. The Credentialing Manager/Director is the HealthKeepers, Inc. authorized representative for initiating the reporting of adverse actions. The HealthKeepers, Inc.'s credentialing staff will compile the necessary information following HealthKeepers, Inc. Credentials Committee action and submit the appropriate forms for review by the HealthKeepers, Inc.'s legal counsel. After review and confirmation by legal counsel, the Credentialing Manager/Director will notify via IQRS the state licensing agency, NPDB as required by law. The Chair of the CC will have final approval and signature on all Adverse Action Reports when required or appropriate. All reports made to NPDB shall be in accordance with the current guidelines established for such databank.

B. Reporting Requirements to the National Practitioner Data Bank
All providers are subject to reporting of adverse actions. In addition, other allied health professionals may be subject to reporting under certain circumstances. Full description regarding requirements for allied health professionals is available on the internet at **https://npdb.hrsa.gov**.

All reports to the NPDB must be submitted electronically. Reports will be submitted via the Internet using the Integrated Querying and Reporting Service (IQRS) or on diskette in a format specified by the NPDB. Details on the format specified for submissions may be obtained by calling the NPDB Help Line at **800-767-6732**.

HealthKeepers, Inc. will notify the State Licensing Agency on the Adverse Action Report form (available electronically to NPDB authorized entities) within 15 days of the date of any final reportable action taken against a practitioner for a period longer than 30 days that adversely affects the Practitioner's participation in the HealthKeepers, Inc.'s programs or networks, any voluntary surrender of participation or privileges by a practitioner under investigation by the Credentials committee for possible incompetence or improper professional conduct, or voluntary surrender of participation or privileges by the practitioner in lieu of such investigation.

Prior to mailing the Adverse Action Report to the applicable State Agency, the form must, at a minimum be, reviewed by the HealthKeepers, Inc.'s legal counsel and Medical Director. Once the form has been reviewed by the HealthKeepers, Inc.'s

legal counsel, Medical Director and any other appropriate parties, the HealthKeepers, Inc.'s credentialing staff will send the written statement.

C. Reporting Errors, Omissions, and Revisions

1. Any errors/omissions to an Adverse Action Report found after a report has been filed with the State Agency and/or the NPDB must be sent to the State Agency and/or NPDB as soon as possible to prevent the disclosure of any inaccurate or incomplete information.
2. If errors or omissions are found after information has been reported, corrections must be submitted via IQRS. When the NPDB processes a correction submitted via the IQRS, a Report Verification document is stored for the reporting entity to retrieve through the IQRS. When a correction is submitted on diskette, the Report Verification document is sent to the reporting entity via the U.S. Postal Service. Additionally, a Report Revised, Voided, or Status Changed document is mailed to the subject of the report and all queries who received the previous version of the report within the past 3 years. HealthKeepers, Inc. and the practitioner should review the information to ensure that it is correct.
3. If errors or omissions are found after information has been reported to State Licensing Agency, corrections must be submitted by annotating the "Report Verification Document" or by submitting a new, fully completed "Adverse Action Report" form. There are two categories of changes to an "Adverse Action Report," CORRECTION OR ADDITION and VOID PREVIOUS REPORT. A CORRECTION OR ADDITION supersedes, or adds information to, the current version of a report. A VOID PREVIOUS REPORT retracts a report in its entirety, and the report is treated as though it had not been submitted (in other words, a report was made on the wrong Practitioner)
4. A "Revision to Action" is a new action that is related to and modifies a previously submitted adverse action. If adverse action information was reported, then any revisions to that action must also be reported. When the NPDB processes a Revision to Action submitted via the IQRS, a Report Verification document is stored for the reporting entity to retrieve through the IQRS. When a Revision to Action is submitted on diskette, the Report Verification document is sent to the reporting entity via the U.S. Postal Service. Additionally, a Notification of a Report in the NPDB is mailed to the subject of the report. HealthKeepers, Inc. and the practitioner should review the information to ensure that it is correct.
5. Revisions are subject to the same time constraints and procedures as the initial action. Revisions include reversal of a Professional Review Action or reinstatement of the Practitioner's participation in HealthKeepers, Inc.'s programs or networks.

D. NPDB Reporting Questions:

Then questions arise regarding querying or reporting requirements, the Compliance Staff will call the NPDB Hotline for assistance at **800-767-6732**. The calls will be

documented with date and time, person spoken to, and a brief narrative of the call. Assistance from the HealthKeepers, Inc.'s legal counsel will also be sought as necessary.

Policy 12: Ongoing Sanction Monitoring

Credentialing associates perform ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department will review periodic listings/reports within 30 days of the time they are made available from the various sources including, but not limited to, the following:

1. Office of the Inspector General
2. Federal and State Medicare/Medicaid Reports
3. Office of Personnel Management
4. State licensing Boards/Agencies
5. Member/Customer Services Departments.
6. Clinical Quality Management Dept. (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
7. Other internal HealthKeepers, Inc. Departments
8. Any other verified information received from appropriate sources

External sources (1-4) will be queried every 6 months if they do not publish information on a set schedule. For these sources, the review will take place when the oversight entity has come to its final determination including but not limited to: Probations, Sanctions, Warnings, Public Notices of Poor Performance, or Reprimands. Interim determinations indicating that a case is under investigation will not be reviewed until a determination has been issued.

Internal sources (5-8) used to review complaints will be queried every 6 months if they do not provide information on a regular schedule that is more frequent than this. Adverse events will be queried monthly.

When a participating practitioner or HDO has been identified by these sources, credentialing criteria will be used to assess the appropriate response. These responses include, but not limited to: review by the Chair of the HealthKeepers, Inc.'s Credentials Committee (CC), review by the HealthKeepers, Inc.'s Medical Director, referral to the CC, or termination.

Procedures

Credentialing staff will review information from the previously referenced external sources as well as periodic information submitted by internal departments to the credentialing department.

A. Sanction and Exclusion Monitoring

If information regarding a participating practitioner or HDO is identified in an external source, the Practitioner's or HDO's applicable credentialing information will be forwarded to the Chair/Vice Chair of the CC, or HealthKeepers, Inc. Medical Director or designee to determine the urgency of the need for response. If urgent action is required, the practitioner or HDO may be subject to the Immediate Termination process. Providers who are approved for immediate termination are reported at the next CC. If urgent action is not required, the Practitioner's or HDO's file will be prepared for the next scheduled CC meeting. HealthKeepers, Inc. may request additional documentation from the reporting agency and/or the Provider at any point in the monitoring process. The issues will be reviewed in light of predetermined criteria, either credentialing eligibility standards, or performance monitoring standards.

B. Performance Monitoring

HealthKeepers, Inc.'s credentialing department will incorporate internal information regarding a Practitioner's performance in the ongoing monitoring process whenever such information is available.

1. Sources for this include, but are not limited to
    a. Quality Improvement activities,
    b. Quality Reviews of complaints from any credible source,
    c. Individual case review performed by internal quality departments,
    d. Adverse events or outcomes review
    e. Medical records reviews
    f. Member's complaints and grievances.
2. For recurrent information types, the applicable HealthKeepers, Inc.'s quality review committee may establish specific thresholds that may indicate problems with professional conduct and competence
3. All referrals from internal sources will have been reviewed by an appropriate internal HealthKeepers, Inc. review committee prior to their submission to the credentialing department. These will be referred to credentialing when the results of that internal review are such that consideration of formal credentialing action is warranted.
4. Internal sources may be queried periodically (at least every 6 months) or internal departments may provide reports on a periodic basis (at least every 6 months) to detect any trends, problems and issues regarding individual practitioners or HDOs. Adverse events will be queried monthly.
5. If the credentialing staff determines that the practitioner or HDO has exceeded predetermined thresholds as described above, the Practitioner's or HDO's

credentialing information will be reviewed with the Credentialing Manager and the Manager of the department making the report, or his or her designee. This review should include all information from the reporting department, any corrective actions, plans, and correspondence sent to the practitioner or HDO from the reporting department to help ensure that the appropriate internal HealthKeepers, Inc. quality review committee has occurred and that the referral to credentialing is appropriate

6. All the information obtained pursuant to this review will become part of the Practitioner's or HDO's credentialing information and be forwarded for review by the Chair of the CC or designee. The Chair of the CC or designee will review the file to determine if the issues of professional competence or conduct are of an urgent nature to warrant Immediate Termination. If the issues do not warrant Immediate Termination, the Provider is referred to the CC.

Policy 13: Appeals – Practitioners

Initial applicants denied network participation may submit additional information as an Informal Review/ Reconsideration. In those limited instances when the refusal of network participation results in a unique NPDB report by HealthKeepers, Inc., the initial applicant may also pursue a Formal Appeal.

Participating practitioners whose network participation has been terminated for professional conduct and competence reasons by HealthKeepers, Inc.'s Credentialing Committee (CC), including immediate termination imposed due to HealthKeepers, Inc.'s determination that the Practitioner's continued participation poses an imminent risk of harm to the HealthKeepers, Inc.'s Members, or when termination requires a unique report to the NPDB may request an Informal Review/Reconsideration as well as pursue a Formal Appeal.

Participating practitioners whose network participation has been terminated due to an Adverse Administrative Action or for professional conduct and competence reasons which do not require CC review (for example, failure to obtain board certification, lack of hospital privileges) are eligible for Informal Review/Reconsideration but not eligible for Formal Appeal.

Participating practitioners whose network participation has been terminated due to the Practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for Informal Review/Reconsideration or Formal Appeal.

Participating practitioners whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for Informal Review/Reconsideration or Formal Appeal.

Procedures

Informal Review/Reconsideration.

A. Notice

1. Terminations of Participating Providers

   When participation was terminated for professional conduct and competence reasons by HealthKeepers, Inc.'s CC or when termination requires a report to the NPDB, the credentialing staff will notify the practitioner of the decision. The notice will contain:

   a. the reason for the decision,
   b. statement that the practitioner has the opportunity for an Informal Review/ Reconsideration of the decision and that the practitioner has the right to submit additional information to HealthKeepers, Inc. to correct any errors in the factual information which led to the determination or provide other relevant information,
   c. a summary description of the Informal Review/Reconsideration,
   d. a statement that the practitioner has the right to waive the Informal Review and proceed directly to a Formal Hearing, and the consequences of waiving this right,
   e. a statement that the practitioner must submit, within the thirty (30) calendar day period immediately following the date of receipt of the letter (unless otherwise required by state regulation), a written request to the credentialing department for a review of the decision, along with any additional information the practitioner wishes to be considered.

2. Denial of Initial Applicants

   When initial application is rejected by HealthKeepers, Inc.'s CC, the credentialing staff will notify the practitioner of the decision. The letter will contain: the reason for the decision, a statement that the practitioner has the opportunity for an Informal Review/Reconsideration of the decision and that the practitioner has the right to submit additional information to HealthKeepers, Inc. to correct any errors in the factual information which led to the determination or provide other relevant information, and a statement that the practitioner must submit, within the thirty (30) calendar day period immediately following the date of receipt of the letter (unless otherwise required by state regulation), a written request to the Credentialing Department for a review of the decision, along with any additional information the provider wishes to be considered.

   Note: A request for an Informal Review/Reconsideration shall stay the effective date of the termination unless otherwise required by state law or regulation or by contract.

B. Request for Reconsideration/Informal Review

   The practitioner may request a Reconsideration/Informal Review of a CC decision which is adverse to the Practitioner's network participation. This request must be in writing, sent via certified mail, and received by the credentialing department within

thirty (30) calendar days (unless otherwise required by state regulation) of the date the practitioner received the letter from HealthKeepers, Inc. with its determination based on the committee results or the Practitioner will forfeit his or her right to request a Reconsideration/Informal Review.

C. Process
    1. Additional information submitted subsequent to the initial decision will be reviewed by the credentialing staff for Informal Review/ Reconsideration along with the information used as the basis for the initial decision and forwarded to the CC for review at its next meeting. The practitioner under review may provide written information, but is not present during the CC meeting. For initial determinations, if the information submitted by the practitioner contains no new objective information, it may be presented in summary form.

D. Reconsideration/Informal Review
The CC will review the additional information submitted by the practitioner along with the information obtained during the initial credentialing, re-credentialing or ongoing monitoring process and the basis for its initial decision at a regularly scheduled CC meeting or at a special review meeting. The CC will then determine whether to uphold or overturn its initial decision.

E. Review Results
The CC decision on the Reconsideration/Informal Review is reported to the credentialing department within five (5) business days of its decision. The credentialing staff then notifies the practitioner within fourteen (14) calendar days of the decision. For practitioners requesting Reconsideration/Informal Review of a denial for initial participation in HealthKeepers, Inc.'s networks this is the final level of review, unless HealthKeepers, Inc.'s action is to be reported to the NPDB. Whenever an action is to be reported to the NPDB, the practitioner will be afforded the right to a Formal Appeal.

F. Notice
The notice of the outcome of the Reconsideration/ Informal Review will contain:
    1. The reason for the decision;
    2. Where a practitioner is eligible for Formal Appeal, a statement that:
        a. The practitioner has the opportunity to submit additional information to HealthKeepers, Inc. for appeal of the decision; and
        b. A summary description of the appeal process described below.
    3. A statement that, if the practitioner desires an appeal, the practitioner must submit, within the thirty (30)-calendar-day-period immediately following the date of receipt of the notice (unless otherwise required by state regulation):
        a. A written request to the credentialing department for an appeal of the decision; and
        b. Any additional information the practitioner wishes to be considered.

When the practitioner is eligible for and requests a Formal Appeal, the effective date of the termination, unless otherwise required by state law or regulation or by contract, will be delayed until the date the Formal Appeal hearing decision is rendered or a decision not to continue pursuing a hearing is communicated by the practitioner to credentialing staff.

Formal Appeal

A. Formal Appeal Hearing, Upon Request.

A practitioner who has been terminated from the network or whose denial for initial participation will be reported to the NPDB may request a formal appeal hearing. This request must be in writing and received via certified mail within the thirty (30) calendar day period immediately following the date of the Practitioner's receipt of the notice from HealthKeepers, Inc. otherwise he or she will forfeit his or her right to a hearing. If a practitioner timely requests a hearing, the following procedures will be followed:

1. The credentialing staff will notify HealthKeepers, Inc.'s medical director, and HealthKeepers, Inc.'s legal counsel, of the Practitioner's request for a hearing.
2. Hearing Panel. HealthKeepers, Inc.'s medical director or designee will select the members of the hearing panel. The hearing panel will be comprised as set forth below unless other panel criteria may be required under applicable law:
    a. Three (3) to seven (7) practitioners not involved in the original decision:
        i. Must be credentialed and by HealthKeepers, Inc. and in good standing;
        ii. The hearing panel will be chaired by HealthKeepers, Inc.'s Medical Director, or designee, who is entitled to vote and who is counted as a member of the hearing panel;
        iii. May not be the same individual who chair or vice-chairs the geographic CC;
        iv. No person who is in direct economic competition with the practitioner may serve on the hearing panel; and
        v. Only hearing panel members not involved in the original decision may vote.

    At least one of the hearing panel members will be a Clinical Peer.
3. Additional hearing panel criteria for physicians that participate in Medicare Advantage (MA) products:
    a. The majority (for example, two out of a typical 3 member panel) of the hearing panel members will be Clinical Peers.
4. Hearing Notice. Within thirty (30) business days of receipt by HealthKeepers, Inc. of a Practitioner's request for a Formal Appeal, the credentialing staff will send a written statement notifying the practitioner of the date, time, and place of the formal hearing. It will advise the practitioner that he/she may appear by telephone, videoconference, or in person (when available) or by telephone. This letter will also summarize the hearing procedures and notify the practitioner that

he or she may appear with a legal representative or other designee before the hearing panel, and that such practitioner has the right to:

a. have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated with the preparation thereof;
b. call, examine, and cross-examine witnesses;
c. present evidence determined to be relevant by the hearing panel regardless of its admissibility in a court of law;
d. be represented by an attorney or another person of their choice,
e. submit a written statement at the close of the hearing, and
f. receive upon completion of the hearing, the written decision of the panel, including a statement of the basis for the decision.
g. Such notice will also state that the practitioner will forfeit his or her right to a hearing if the practitioner (1) does not respond to the notice to confirm the date, time, and place of the formal hearing within fourteen (14) business days following receipt of the notice by the Provider (2) cancels within seven (7) days of the scheduled hearing without good cause; or (~~2~~ 3) fails to attend the scheduled hearing (either in person or by telephone) without good cause. Hearings may be rescheduled a maximum of two (2) times, unless good cause is provided. If a practitioner has forfeited his or her right to a hearing, the Adverse Credentialing Decision with stand.

5. In advance of the hearing, the Credentialing staff will give each hearing panel member a copy of the denial and/or termination letter originally sent to the applicable Practitioner. The panel members may also be provided with any other material deemed relevant by HealthKeepers, Inc. at or in advance of the hearing.
6. Hearing Date. The hearing date will be not less than 30 nor more than 60 calendar days after the date of the notice given to the practitioner of the date, time, and place of the formal hearing or as otherwise agreed to by HealthKeepers, Inc. and the affected Practitioner.

B. Hearing Procedures.

The chairperson of the hearing panel, who is a HealthKeepers, Inc. medical director or his or her designee, will open the hearing by stating the purpose and protocol of the hearing.

1. During the hearing, the practitioner will have the ability to exercise any or all of the rights set forth in Section 1(d), Hearing Notice above.
2. A representative of HealthKeepers, Inc. will present the reasons for the decision to reject or terminate the Practitioner.
3. The practitioner will present reasons why his or her participation should not be rejected or terminated.
4. Before the close of the hearing, each side may briefly summarize its position for the hearing panel if it chooses.

5. The maximum duration of the hearing will be two hours unless the chairperson of the hearing panel, in his or her discretion, determines that the hearing cannot reasonably be concluded in that time period.
6. The hearing panel will meet privately after the hearing to reach a decision. Each voting member of the hearing panel will have one equal vote. The hearing panel will have the authority to uphold, reject, or modify the original decision based on a preponderance of evidence presented at the hearing. The decision must be reached by a majority vote.
7. The hearing panel will prepare a written decision, including the rationale, for its decision.

C. Review Results and Notice
HealthKeepers, Inc.'s medical director shall report the decision of the hearing panel to the credentialing department within five (5) business days of the date of the hearing. The credentialing staff shall notify the practitioner ithin ten (10) calendar days of receiving notification from the medical director of the hearing panel's decision and rationale.

Reporting Final Adverse Actions:
HealthKeepers, Inc. will report any final adverse actions in accordance with Credentialing Policy.

Policy 14: Appeals – Facilities

It is the intent of HealthKeepers, Inc. to give HDOs the opportunity to appeal a termination of the HDOs participation in one or more of HealthKeepers, Inc.'s provider network(s) or programs. Immediate terminations may be imposed due to the HDOs loss of licensure, criminal conviction of one of the principal officers of the HDO or HealthKeepers, Inc.'s determination that the HDOs continued participation poses an imminent risk of harm to HealthKeepers, Inc.'s Members, or the HDO has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs. An HDO whose license has been suspended or revoked has no right to Informal Review/Reconsideration or Formal Appeal. An HDO whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for Informal Review/Reconsideration or Formal Appeal.

Informal Review/Reconsideration:

Notice: Terminations of Participating Providers:
Upon decision by the geographic CC to terminate an HDO's participation, the credentialing staff will notify the HDO of the decision. The notice will contain the reason for the decision, a statement that the Provider has the opportunity for an Informal Review/ reconsideration of the decision, a statement that the provider has the right to submit additional information to HealthKeepers, Inc. for Informal Review/Reconsideration and a summary description of the review process described

below. In addition, the notice will also advise that the HDO has the right to waive the Informal Review thus proceeding to a Formal Hearing, and that proceeding directly to a Formal Hearing waives any future right to an Informal Hearing. The notice also will state that if the Provider desires any further review, the HDO representative must submit, within the thirty (30) calendar day period immediately following the date of receipt of the letter (unless otherwise required by state regulation), a written request to the credentialing department for a review of the decision, along with any additional information the Provider wishes to be considered. A request for any additional review shall stay the effective date of the termination unless otherwise required by state law or regulation or by contract. For information regarding immediate terminations, see Credentialing Policy #10.

A. Request for Reconsideration/Informal Review:
   The HDO may request a Reconsideration/Informal Review of the geographic CC's decision if the decision of the geographic CC is adverse to the provider. This request must be in writing, sent via certified mail, and received by the credentialing department within the thirty (30) calendar day period immediately following the date of the HDO's receipt of the letter from HealthKeepers, Inc. (unless otherwise required by state regulation), with its determination based on the committee results.
B. Process:
   Any additional information submitted subsequent to the initial decision will be reviewed by the credentialing staff for Informal Review/Reconsideration. The credentialing staff will review the information used as the basis for the initial decision, along with any additional information submitted by the HDO and if appropriate, forward the matter including any additional information submitted by the HDO to the geographic CC at its next meeting. No representatives of the HDO shall be present during the Informal Review/Reconsideration. For initial determinations, if the information submitted by the HDO contains no new objective information, it may be presented in summary form.
C. Informal Review/Reconsideration:
   As reconsideration, any additional information submitted subsequent to the initial decision of the geographic CC will be presented to the committee for its consideration. All of the conditions of Credentialing Policy #3 with regards to the geographic CC apply. The geographic CC will review the information obtained during the credentialing process and the basis for its initial decision, along with any additional information submitted by the HDO. This review may take place at regularly scheduled geographic CC meeting or at a special review meeting. The representatives of the HDO shall not be present during the review. HealthKeepers, Inc. may have credentialing staff, network service representatives and legal representatives present for the first level review as non-voting members.
D. Review Results:
   The geographic CC shall report its decision on the Reconsideration/Informal Review to the credentialing department within five (5) business days of its decision. The

credentialing staff shall notify the HDO within fourteen (14) calendar days of the decision.

Formal Appeal Process:

Notice:

1. Upon notification that Reconsideration/Informal Review of a decision to terminate an HDO's participation of a Professional Review Action was upheld by the geographic CC, the credentialing staff will notify the entity of the decision. The notice will:
    a. Contain the reason for the decision;
    b. Where an HDO is eligible for Formal Appeal, a statement that:
        i. The HDO has the opportunity to submit additional information to HealthKeepers, Inc. for appeal of the decision; and
        ii. A summary description of the appeal process described below.
    c. State that if the HDO desires an appeal, the entity must submit, within the thirty (30)-calendar-day-period immediately following the date of receipt of the notice (unless otherwise required by state regulation):
        i. Written request to the credentialing department for an appeal of the decision; and
        ii. Any additional information the HDO wishes to be considered.
2. A request for a Formal Appeal shall stay the effective date of the termination, unless otherwise required by state law or regulation or by contract.

Formal Appeal Hearing, Upon Request:

A HDO which has been terminated from the network may request a formal appeal hearing if the decision of the first level review is adverse to the HDO or if the right to first level review was waived by the HDO. This request must be in writing and received via certified mail within the thirty calendar (30) day period immediately following the date of the HDO's receipt of the notice from HealthKeepers, Inc. If an HDO timely requests a hearing, the following procedures will be followed:

The credentialing staff will notify HealthKeepers, Inc.'s Medical Director, and HealthKeepers, Inc.'s legal counsel, of the Provider's request for a hearing.

Hearing Panel:

HealthKeepers, Inc.'s Medical Director or designee will select the members of the hearing panel. The hearing panel will be comprised of at least three (3) individuals not involved in the original decision. Only hearing panel members not involved in the original decision may vote. No person with an economic interest in an entity in direct competition with the appealing HDO may serve on the hearing panel. At least one of the hearing panel members will be a participating provider with some experience with the type of HDO in question, but without any other role in network management. The

hearing panel will be chaired by HealthKeepers, Inc.'s Medical Director, or designee, who is entitled to vote and who is counted as a member of the hearing panel.

Hearing Notice:
Within thirty (30) business days of receipt by HealthKeepers, Inc. of a request for a Formal Appeal, the credentialing staff will send a written statement notifying the HDO of the date, time, and place of the formal hearing. It will advise the representatives of the HDO that it may have its representative appear by telephone, videoconference, or in person (when available). This letter will also summarize the hearing procedures and notify the HDO representative that he or she may appear with a legal representative or other designee before the hearing panel, and that the entity and its representatives have the right to:

1. Have a record made of the proceedings, copies of which may be obtained by representative(s) of the HDO upon payment of any reasonable charges associated with the preparation thereof;
2. Call, examine, and cross-examine witnesses;
3. Present evidence determined to be relevant by the hearing panel regardless of its admissibility in a court of law;
4. Be represented by an attorney or another person of their choice;
5. Submit a written statement at the close of the hearing;
6. Receive upon completion of the hearing, the written decision of the panel, including a statement of the basis for the decision.

   Such notice will also state that the HDO will forfeit its right to a hearing if the representative(s) of the HDO: (1) does not respond to the notice to confirm the date, time, and place of the formal hearing within fourteen (14) business days following receipt of the notice by the representative(s) of the HDO; (2) cancels within seven (7) days of the scheduled hearing without good cause; or (3) fail(s) to attend the hearing without good cause or request a hearing within thirty (30) days. If a HDO has forfeited the right to a hearing, the Adverse Credentialing Decision with stand.

   In advance of the hearing, the Credentialing staff will give each hearing panel member a copy of the denial and/or termination letter originally sent to the applicable HDO. The panel members may also be provided with any other material deemed relevant by HealthKeepers, Inc. at or in advance of the hearing.

Hearing Date:
The hearing date will be not less than thirty (30) nor more than sixty (60) calendar days after the date of the notice given to the HDO of the date, time, and place of the formal hearing or as otherwise agreed to by HealthKeepers, Inc. and the affected HDO.

A. Hearing Procedures:
   The chairperson of the hearing panel, who is the Medical Director or his/her designee, will open the hearing by stating the purpose and protocol of the hearing.

1. During the hearing, the HDO representative will have the ability to exercise any or all of the rights set forth in Section “Hearing Notice” above.
2. A representative of HealthKeepers, Inc. will present the reasons for the decision to reject or terminate the HDO.
3. The representative of the HDO will present reasons why his or her participation should not be rejected or terminated.
4. Before the close of the hearing, each side may briefly summarize its position for the hearing panel if it chooses.
5. The maximum duration of the hearing will be two hours unless the chairperson of the hearing panel, in his or her discretion, determines that the hearing cannot reasonably be concluded in that time period.
6. The hearing panel will meet privately after the hearing to reach a decision. Each voting member of the hearing panel will have one equal vote. The hearing panel will have the authority to uphold, reject, or modify the original decision based on a preponderance of evidence presented at the hearing. The decision must be reached by a majority vote.
7. The hearing panel will prepare a written decision, including the rationale, for its decision.

B. Review Results:
HealthKeepers, Inc.’s Medical Director shall report the decision of the hearing panel to the credentialing department within five (5) business days of the date of the hearing. The credentialing staff shall notify the HDO within ten (10) calendar days of receiving notification from the Medical Director of the hearing panel’s decision and rationale.

C. Reporting Final Adverse Actions:
HealthKeepers, Inc. will report any final adverse actions in accordance with applicable local regulations.

Policy 15: Reapplication after Termination or Denial

The timeline that permits practitioners or HDOs the opportunity to reapply for participation in one or more of the HealthKeepers, Inc.’s programs or networks, after a Professional Review Action has been taken by the HealthKeepers, Inc. Credentials Committee (CC) to deny or terminate the Practitioner’s or HDO’s participation varies depending upon the issues involved and is set forth herein. This policy is not intended to define reapplication time frames for denials or terminations taken for administrative and/or business reasons.

Nothing in this Policy requires HealthKeepers, Inc. to automatically accept previously denied or terminated practitioners. Practitioners and HDOs reapplying for participation

or requesting reinstatement in one or more of HealthKeepers, Inc.'s programs or networks, must complete an application, meet current participation criteria, and be approved by the CC.

Provider Procedures

A. Failed site visit (where applicable):
   A practitioner (or HDO) may reapply once the location undergoes a site visit by HealthKeepers, Inc., or its designee, that meets HealthKeepers, Inc.'s standards.
B. Physical/mental impairment:
   A practitioner may reapply upon HealthKeepers, Inc.'s receipt of documentation from the Practitioner's treating physician that the practitioner is physically and mentally capable to perform within the scope of practice for which application is made and that the Practitioner's status does not suggest future probable substandard professional conduct and competence.
C. Suspension of hospital privileges:
   A practitioner may reapply upon HealthKeepers, Inc.'s receipt of documentation from the hospital or other applicable authority that the action has been cleared OR may reapply after a period of one (1) year after the final action and the practitioner has privileges at an appropriate Professional.
D. Chemical/Substance Use Disorder:
   Reapplication may occur when either one of the following are met whichever occurs first:
   1. If this licensing agency has taken action related to substance use disorder, a practitioner may reapply after a period of one year of active participation in a treatment program, with receipt of a statement or other legally required documentation from the Practitioner's supervising physician and any applicable State required program for impaired practitioners. This statement must indicate that the practitioner is in a successful maintenance program with no evidence of recidivism and the Practitioner's status does not suggest future probable substandard professional conduct and competence. OR
   2. A practitioner may reapply upon removal of all licensure encumbrances, have been removed.
E. Falsification on application or supporting documentation:
   A practitioner or HDO may reapply one (1) year after the occurrence.
F. Restricted DEA and/or State Certification:
   A practitioner or HDO may reapply upon HealthKeepers, Inc.'s receipt of documentation from the applicable authority that the restrictions have been lifted.
G. License Sanctions:
   A practitioner may reapply upon HealthKeepers, Inc.'s receipt of documentation from the applicable authority that the license is no longer sanctioned/encumbered.
H. Other Quality Issues:
   A practitioner or HDO may reapply after a period of one (1) year from the date of the final determination.

I. Malpractice History:
   A practitioner or HDO may reapply after a period of one (1) year from the date of the final determination.
J. Felony Convictions:
   A practitioner may reapply after a period of one (1) year has elapsed from the date of the conviction or conclusion of sentencing, incarceration/obligation, whichever is later.
K. State or Federal Sanctions and Exclusions:
   A practitioner or HDO may reapply once the sanction is lifted.
L. Other Issues of Professional Conduct or Competence:
   A practitioner or HDO may reapply after a period of one (1) year.

The CC retains, solely at its discretion, the right to reduce the period of time for the Provider to reapply.

Policy 16: Practitioner Physical & Mental Health Conditions and Impairments

The purpose of this policy is to provide guidelines for credentialing, recredentialing or interim assessments by the Credentialing Committee of practitioners (whether current Participating practitioners or applicants) to whom any of the following apply: 1) are acknowledged to have a mental health or substance use disorder; or 2) have undergone treatment for a mental health or substance use disorder in the past three years ;or 3) have a physical impairment that may negatively impact their ability to provide care to patients or pose a risk of harm to patients. Information regarding presence or history of a mental health condition(s), substance use disorder, and/or physical condition(s) and/or impairment(s) is found through disclosure on the Practitioner's application for participation in a network, through primary source verifications or databank queries in the process of credentialing, or other credible sources.

A. Practitioners (whether current Participating practitioners or applicants) who are identified as having a mental health or substance use disorder for which they are currently undergoing treatment or for which they have undergone treatment in the past three years, or identified to have a physical condition(s) and/or impairment(s) that could interfere with their ability to perform the scope of care expected by a practitioner in his/her Specialty or whose condition could pose a risk of harm to enrollees will be individually reviewed by the Credentialing Committee.
B. Practitioners (whether current Participating practitioners or applicants) and who have issues related to substance use disorder must provide information that he/she is currently in or has successfully completed an ongoing treatment and/or monitoring program. The information reviewed must not raise a reasonable suspicion of substandard professional conduct and competence, or that the Practitioner's history does not adversely affect patient safety.

C. For initial applicants, the criteria related to license status discussed in prior criteria is applicable.
D. For initial applicants who disclose information regarding substance use disorder or other impairment and whose license status has not been affected, the Credentials Committee shall use discretion to determine what constitutes a satisfactory length of time in a treatment or a reasonable practice setting.
E. For Participating practitioners whose license status has been affected because of substance use disorder, the information must indicate a documented period of no less than one (1) year since initiation of a successful, supervised treatment in a program with no evidence of recidivism since that time.
F. For Participating practitioners with substance use disorder or other impairments whose license has not been affected by the substance use disorder or impairment, the Credentials Committee shall use discretion to determine what constitutes a satisfactory length of time in a treatment or monitoring program and may then require documentation in support of that requirement.
G. In any instance where there is reasonable concern regarding impairment, the Credentials Committee may, at its discretion require whatever additional monitoring or follow up information it deems appropriate.
H. Practitioners who fit the descriptions noted above may be asked to have their treating physician submit directly to the Credentialing Department, information noting whether their condition in any way impairs their ability to practice or in any way poses a risk of harm to patients or raises a reasonable suspicion of substandard professional conduct or competence. Practitioners will be required to authorize the release of such information to the CC in order for the participation to be evaluated. Additionally, the treating physician will be asked to agree to notify the Credentialing Department if, at any time during treatment of the Practitioner, it becomes apparent that the Practitioner's condition could impair the Practitioner's ability to practice or could pose a risk of harm to patients.
I. The information obtained will be considered when the Credentialing Committee makes its decision regarding network participation.

Procedures

A. When information is received that a Practitioner:

1. Has a mental health condition and is currently undergoing treatment or has undergone treatment in the past three years, or
2. Has a medical condition or impairment affecting his or her ability to perform his or her professional duties or when such information is found through primary source verifications or databank queries in the process of credentialing, or

B. Is undergoing treatment for, or has a history of, substance use disorder. The practitioner may:

Be advised, in writing, that to be considered for network participation (new or continued) it will be necessary for the Practitioner to authorize their treating physician to provide written substantiation to the Credentialing Department noting whether the Practitioner's condition in any way impairs his/her ability to practice or could pose a risk of harm to patients or suggest future probable substandard professional conduct or competence.

C. Once the letter from the treating physician is received, information from the Practitioner's application, including documentation from the treating physician will be individually reviewed by the Credentialing Committee.

Policy 17: Specialty Designations

A. HealthKeepers, Inc. recognizes all provider specialty designations recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC). Additionally, specialties not recognized by the ABMS, AOA, RCPSC or CFPC but for which the Accreditation Council for Graduate Medical Education (ACGME) has designated accredited training programs will be eligible for recognition if deemed acceptable by the National Credentials Committee.

B. For provider types which are in the scope of the credentialing program, but for which the ABMS/AOA/RCPSC/CFPC/ACGME is not applicable, the National Credentials Committee will establish acceptable education and training requirements for recognition (see below) Any specialty recognized by HealthKeepers, Inc. is eligible for use in provider directories, but determination of need for a specific eligible specialty designation is that of HealthKeepers, Inc. In situations where there are extenuating or special circumstances an Access Needs Waiver must be completed and reviewed by the National Credentials Committee.

HealthKeepers, Inc. recognized specialty types with education and training requirements:

Provider Type	Training Requirements
General Practice NCC Approval date: 03/13/2015	Meets the criteria outlined in Credentialing Policy #4.0.

Provider Type	Training Requirements
Gynecology NCC Approval Date: 12/21/05	Same training as obstetrics/gynecology (4 years accredited graduate medical education in an Obstetrics/Gynecology program with no less than 36 months of clinical Obstetrics/Gynecology). This designation is per the applying physician's choice in place of, but in addition to, the designation of obstetrics/gynecology.
Internal Medicine and Pediatrics NCC Approval Date: 12/21/05	1. Board Certified in both Internal Medicine AND Pediatrics OR 2. Successful completion of a dual residency program in internal medicine AND pediatrics with the stipulation that certification in both Internal Medicine and Pediatrics will be obtained within five years.
Addiction Medicine NCC Approval Date: 11/12/21	. ABMS recognized pathway through psychiatry, American Board of Preventive Medicine, or AOA certification.
Sleep Medicine NCC Approved	Certification by a primary specialty board that is recognized by the ABMS or the AOA and 1 full year of additional training in Sleep Medicine (PGY 3 or later via a Fellowship in Sleep Medicine or through an equivalent training period in an alternate ACGME approve program such as training in Sleep Medicine that takes place in a fellowship program in Pulmonary Medicine or Clinical Neurophysiology).
Pediatric Orthopedics NCC Approval Date: 12/21/05	Completion of a recognized ACGME training program in Pediatric Orthopedics OR Board Certified in Orthopedics and having privileges in orthopedics at a pediatric specialty hospital.
Pediatric Urology NCC Approval Date: 12/21/05	Completion of a recognized ACGME training program in Pediatric Urology OR Board Certified in Urology and having urology privileges at a pediatric specialty hospital.

Provider Type	Training Requirements
Pediatric Ophthalmology NCC Approval Date: 12/21/05	Board Certified in Ophthalmology and having privileges in ophthalmology at a pediatrics specialty hospital.
Pediatric Neurosurgery NCC Approval Date: 12/21/05	Board Certified in Neurosurgery and having privileges in neurosurgery at a pediatrics specialty hospital.
Pediatric Cardiac Surgery NCC Approval Date: 12/21/05	Board Certified in Cardiovascular Surgery and having privileges in cardiac surgery at a pediatrics specialty hospital.
Pediatric Allergy & Immunology NCC Approval Date: 12/21/05	Board Certified in Allergy & Immunology and two years training in Pediatrics.
Glaucoma NCC Approval Date: 12/21/05	Board Certified in Ophthalmology with one-year fellowship in Glaucoma at an institution with an ophthalmology residency program recognized by ACGME.
Retinal Disease NCC Approval Date: 12/21/05	Board Certified in Ophthalmology with one-year fellowship in Retinal Disease at an institution with an ophthalmology residency program recognized by ACGME.
Adult Reconstructive Orthopedics NCC Approval Date: 12/21/05	Board Certified in orthopedics and completion of a recognized ACGME in Adult Reconstructive Orthopedics.
Foot and Ankle Orthopedics NCC Approval Date: 12/21/05	Board Certified in orthopedics and completion of a recognized ACGME in Foot and Ankle Orthopedics.
Orthopedic Trauma NCC Approval Date: 12/21/05	Board Certified in orthopedics and completion of a recognized ACGME in Orthopedic Trauma.
Orthopedic Surgery of the Spine NCC Approval Date: 12/21/05	Board Certified in orthopedics and completion of a recognized ACGME in Orthopedic Surgery of the Spine.
Pain Medicine NCC Approval Date: 12/21/05	Board Certification in Pain Medicine through ABMS or AOA recognized process or Board Certification by the American Board of Pain Medicine

Provider Type	Training Requirements
Hematology/Oncology NCC Approval Date: 07/10/09	Completion of a recognized ACGME training program in Hematology and Oncology with board certification in both Hematology and Oncology or AOA recognized process.
Developmental-Behavioral Pediatrics	Board certification in Developmental-Behavioral Pediatrics subspecialty through American Board of Pediatrics. Prior to ABMS approval in 1999: completed a two-year Developmental Behavioral Fellowship and documentation of accepted application to sit for the subspecialty board of Developmental-Behavioral Pediatrics or an attestation from fellowship director that fellowship was completed and training is sufficient.

Attachment A: Practitioner Types And Specialties Not Requiring Hospital Privileges

Hospital Privilege requirements apply in general to physician providers, and thus the following provider types are excluded from this requirement. These practice types include:

1. Chiropractors
2. Podiatrists
3. Optometrists
4. Non-physician behavioral health providers (Including but not limited to: Psychologists, Social Workers, Licensed Professional Counselors, Marriage and Family Therapists/ Counselors, Nurse practitioners working in behavioral health)
5. Nurse practitioners, Certified Nurse Midwives, and Physician Assistants
6. Medical Therapists, for example, physical therapists, speech therapists, and occupational therapists, who are within the scope of credentialing (See Credentialing Policy #2)
7. Licensed Genetic Counselors
8. Audiologists
9. Acupuncturists (non-MD/DO)
10. Registered Dietitians

In addition, there are several physician specialty types whose practices are primarily limited to the outpatient arena and thus are exempted from the requirement for hospital privileges. These specialties are:

1. Addiction Medicine/Addictionology

2. Allergy & Immunology
3. Dermatology
4. Genetics
5. Occupational Medicine
6. Pain Management
7. Physical Medicine & Rehabilitation (Physiatrists)
8. Psychiatry
9. Public Health and General Preventive Health
10. Rheumatology
11. Radiation Oncology practicing at a CIHQ, TJC, NIAHO- or ACHC-approved facility
12. Ophthalmology
13. Neuromusculoskeletal Medicine & Osteopathic Manipulative Medicine
14. Primary Care physicians whose patients are admitted to a participating hospital with an established hospitalist program
15. Physicians in any specialty who have been credentialed to participate solely as a Telemedicine Provider (Note: if such a physician later applies to participate as an office-based physician, the hospital privilege requirement may apply)
16. Anesthesiologists practicing in an outpatient setting
17. Radiologists practicing in an outpatient setting.
18. Pathologists practicing in an office setting
19. Nuclear Medicine physicians practicing in an outpatient
20. Developmental-Behavioral Pediatrician practicing in an outpatient setting

All other MD and DO provider types within the scope of the credentialing program, and dentists who practice as Oral-Maxillofacial Surgeons are required to have hospital privileges or appropriate admitting arrangements. This includes all PCP providers (family physicians, pediatricians, internists, & general practitioners) and Specialty Providers other than those specifically exempted by the listings above.

Carelon Behavioral Health, Inc. is an independent company providing utilization management services on behalf of the health plan. CarelonRx, Inc. is an independent company providing pharmacy benefit management 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.

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