Provider Manual

BadgerCare Plus and
Medicaid Supplemental Security Income

Anthem

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Chapter 1: Introduction

Welcome! Thank you for being part of the Anthem Blue Cross and Blue Shield (Anthem) network.

Overview

BadgerCare Plus and Medicaid Supplemental Security Income (SSI) participants have the option of selecting Anthem in all Wisconsin counties effective January 1, 2018.

Anthem represents a growing network of healthcare providers who make it easier for our members to receive quality care. We are committed to ensuring access to all necessary healthcare services and providing first-class customer service by encouraging coordination of physical and behavioral care and emphasizing prevention and education.

We work with many local service and governmental agencies, including:

- Bureau of Milwaukee Child Welfare
- Local health departments
- Prenatal care coordination agencies
- School-based services providers
- Targeted care management agencies

There is strength in numbers; Anthem's health services programs, combined with those already available in our target service areas, are designed to supplement providers' treatment plans. Our programs also serve to help improve our members' overall health by informing, educating, and encouraging self-care in the prevention, early detection and treatment of existing conditions and chronic disease.

About this manual

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

We recognize that managing our members' health can be a complex undertaking, requiring familiarity with the rules and regulations of a complex healthcare system. With this complexity in mind, we divided this manual into sections that reflect your questions, concerns, and responsibilities before and after an Anthem member walks through your doors. The sections are organized as follows:

- Legal requirements
- Contact information
- Before rendering services
- After rendering services
- Operational standards, requirements, and guidelines
- Additional resources

Legal requirements

The information contained in this manual is proprietary, will be updated regularly and is subject to change. This section provides specific information on the legal obligations of being part of the Anthem network.

Contact information

This section is your reference for important phone and fax numbers, websites, and mailing addresses.

Before rendering services
This section provides the information and tools you will need before providing services, including verifying member eligibility and a list of covered and noncovered services. The section also includes a chapter on the precertification process and coordination of complex care through case management.

We take pride in our proactive approach to health. The chapter on "Health Services Programs" details how we can partner with you to make the services you provide more effective. For example, the Initial Health Assessment is our first step in providing preventive care, and the health services programs under Condition Care allow us to collaborate with you to combat the most common and serious conditions and illnesses facing our members, including asthma, cardiovascular disease, and diabetes.

After rendering services
At Anthem, our goal is to make the billing process as streamlined as possible. The After Rendering Services section provides guidelines and detailed coding charts for fast, secure, and efficient billing and includes specific information about filing claims for professional and institutional services. In addition, the "Member Transfers and Disenrollment" chapter outlines the steps for members who want to change their primary care physician (PCP) assignment or transfer to another health plan. When questions or concerns come up about claims or adverse determination, our chapter on grievances and appeals will take you step-by-step through the process.

Operational standards, requirements and guidelines
This section summarizes the requirements for provider office operations and access standards, thereby ensuring consistency when members need to consult with providers for referrals, coordination of care and follow-up care. Additional chapters detail provider credentialing, provider roles and responsibilities, and enrollment and marketing guidelines. Chapters on clinical practice, preventive health guidelines and case management outline the steps providers should take to coordinate care and help members take a proactive stance in the fight against disease. Finally, we included a chapter documenting our commitment to participate in quality assessments that help Anthem measure, compare, and improve our standards of care.

Additional resources
To help providers serve a diverse and ever-evolving patient population, we designed the Culturally and Linguistically Appropriate Services program to improve provider/member communications by providing tools and resources to help reduce language and cultural barriers. In addition, Anthem works with nationally recognized healthcare organizations to stay current on the latest healthcare breakthroughs and discoveries. This manual provides easy links to access that information. We also provide forms and reference guides on a wide variety of subjects.

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

If you have any questions about the content of this manual, contact Provider Services: **855-558-1443**. Hours: Monday to Friday, 8 a.m. to 5 p.m.

Websites
The Anthem website and this manual may contain links and references to internet sites owned and maintained by third-party sites. Neither Anthem nor its related affiliated companies operate or control, in any respect, any information, products or services on third-party sites. Such information, products, services, and related materials are provided "as is" without warranties of any kind, either express or implied, to the fullest extent permitted under applicable laws. Anthem disclaims all warranties, express or implied, including but not limited to implied warranties of merchantability and fitness. Anthem does not warrant or make any representations regarding the use or results of the use of third-party materials in terms of correctness, accuracy, timeliness, reliability or otherwise.

Chapter 2: Legal and administrative requirements

Proprietary information

The information contained in this manual is proprietary. By accepting this manual, providers agree:

- To use this manual solely for the purposes of referencing information regarding the provision of medical services to BadgerCare Plus and Medicaid SSI enrollees who have chosen Anthem as their healthcare plan.
- To protect and hold the manual's information as confidential.
- Not to disclose the information contained in this manual.

Privacy and security

Anthem's latest *HIPAA*-compliant privacy and security statement may be found on our website: **https://providers.anthem.com/WI**. To access this statement, select **Privacy Policies** from the lower right corner of the provider page.

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

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

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

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

Updates and changes

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

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

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

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

Nondiscrimination policy

Anthem does not engage in, aid, or perpetuate discrimination against any person by providing significant assistance to any entity or person that discriminates on the basis of race, color or national origin in providing aid, benefits or services to beneficiaries. Anthem does not utilize or administer criteria having the effect of discriminatory practices on the basis of gender or gender identity. Anthem does not select site or facility locations that have the effect of excluding individuals from, denying the benefits of or subjecting them to

discrimination on the basis of gender or gender identity. In addition, in compliance with the Age Act, Anthem may not discriminate against any person on the basis of age, or aid or perpetuate age discrimination, by providing significant assistance to any agency, organization or person that discriminates on the basis of age. Anthem provides health coverage to our members on a nondiscriminatory basis, according to state and federal law, regardless of gender, gender identity, race, color, age, religion, national origin, physical or mental disability, or type of illness or condition.

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

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

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

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

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

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

- Mail: N17 W 24340 Riverwood Drive, Waukesha, WI 53188
- Phone: 262-523-4920

Equal program access on the basis of gender

Anthem provides individuals with equal access to health programs and activities without discriminating on the basis of gender. Anthem must also treat individuals in a manner consistent with their gender identity, and is prohibited from discriminating against any individual or entity on the basis of a relationship with, or association with, a member of a protected class (that is, race, color, national origin, gender, gender identity, age or disability). Anthem may not deny or limit health services that are ordinarily or exclusively available to individuals of one gender, to a transgender individual based on the fact that a different gender was assigned at birth, or because the gender identity or gender recorded is different from the one in which health services are ordinarily or exclusively available.

Chapter 3: Contacts

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

Anthem and Wisconsin state contacts

If you have questions about...	Contact
Behavioral health services	Anthem Provider Services Phone: 855-558-1443 TTY: **711** Hours: Monday to Friday, 8 a.m. to 5 p.m. All Requests for Prior Authorizations should be submitted using the secure provider platform Availity Essentials* at **http://www.Availity.com**. If you prefer to fax, please use appropriate form posted on **https://providers.anthem.com/WI**.
Case management referrals	Anthem Provider Services Phone: 855-558-1443 TTY: **711** Hours: Monday to Friday, 8 a.m. to 5 p.m. Prior Authorization/Notification Request: Fax: 800-964-3627
Claims: Electronic claims (electronic data interchange – EDI)	Availity Client Services: **800-AVAILITY (282-4548)** Hours: Monday to Friday, 8 a.m. to 8 p.m. EST Website (secure provider website): Availity at **http://www.Availity.com**. Public website: **https://providers.anthem.com/WI**. On the right side of the page, select **Login**. Payer Identification Number: Professional: **00950** Institutional: **00450**
Claims: Status	Website (secure provider website): **http://www.Availity.com**; use the **Claims & Payments** tab Login with User ID and Password Anthem Provider Services Phone: **855-558-1443** Hours: Monday to Friday, 8 a.m. to 5 p.m.
Claims: Appeals/correspondence	Anthem Blue Cross and Blue Shield Correspondence/Appeals P.O. Box 61599 Virginia Beach, VA 23466-1599 Anthem Provider Services Phone: **855-558-1443** Hours: Monday to Friday, 8 a.m. to 5 p.m. **Utilization management appeals:** To file an authorization appeal, the member's authorized representative or the provider acting on

If you have questions about...	Contact
	behalf of the member must notify us within 60 calendar days of the date on the *Notice of Action* denial letter. File the appeal from Availity Essentials at **http://www.Availity.com**. Use the **Patient Registration** tab to access *Authorizations & Referrals.* To mail authorization appeals: Anthem Blue Cross and Blue Shield Central Appeals Processing P.O. Box 62429 Virginia Beach, VA 23466-2429 **Claim dispute/appeal:** Use the secure Provider Availity Payment Appeal Tool at **http://www.Availity.com**. Through Availity, you can also upload supporting documentation and receive immediate acknowledgement of your submission. Locate the claim you want to dispute on Availity using **Claim Status** from the **Claims & Payments** menu. If available, select **Dispute Claim** to initiate the dispute. Go to **Request** to navigate directly to the initiated dispute in the appeals dashboard add the documentation and submit. For appeals, your Availity user account will need the *Claim Status* role. To send attachments from **Claim Status**, you'll need the *Medical Attachments* role.
Claims: Overpayment recovery and refund procedure	Anthem Blue Cross and Blue Shield P.O. Box 933657 Atlanta, GA 31193-3657
Credentialing and Recredentialing	Phone: **855-558-1443** Email: **Credentialing@Anthem.com** Or you can follow credentialing instructions online through Availity at **http://www.Availity.com**.
Dental services: Members who live in Kenosha, Milwaukee, Ozaukee, Racine, Washington, or Waukesha C counties	For all services (including precertification) providers and members should contact DentaQuest.* Website: **www.DentaQuest.com** Provider Services: **855-453-5287** Fax: **262-834-3589** DentaQuest P.O. BOX 2906 Milwaukee, WI 53201-2906 Member Services: 888-271-5210
Dental services: All other counties	For all services (including precertification) providers and members should contact ForwardHealth:* • Phone: **800-947-9627** (providers) • Phone: **800-362-3002** (members) • Hours: Monday to Friday, 7 a.m. to 6 p.m. • Website: **www.forwardhealth.wi.gov**

If you have questions about...	Contact
Fraud and Abuse department	Anthem Provider Services Phone: **855-558-1443** Hours: Monday to Friday, 8 a.m. to 5 p.m.
Grievances and Appeals department	For grievances and appeals, contact Anthem Provider Services: Phone: **855-558-1443** Hours: Monday to Friday, 8 a.m. to 5 p.m. Fax: **800-964-3627** Appeals can be submitted through Provider website: **https://providers.anthem.com/WI** (Select **Login** or **Register** to access the secure site.)
Hospital/facility admission notification	To submit a prior authorization from **http://www.Availity.com** use the **Patient Registration** tab to access *Authorizations & Referrals*. Anthem Provider Services Phone: **855-558-1443** TTY: **711** Hours: Monday to Friday, 8 a.m. to 5 p.m. Preauthorization/notification request: Fax: **800-964-3627**
Interpreter services	Anthem Member Services Phone: **855-690-7800** TTY: **711** Hours: Monday to Friday, 8 a.m. to 5 p.m. After hours, call 24/7 NurseLine: **855-690-7800** TTY: **711** Hours: 24 hours a day, 7 days a week
24/7 NurseLine	Phone: **855-690-7800** TTY: **711** Hours: 24 hours a day, 7 days a week
Medical Management department	Anthem Provider Services Phone: **855-558-1443** TTY: **711** Hours: Monday to Friday, 8 a.m. to 5 p.m. Prior authorization/notification request: Fax: **800-964-3627** Medical Management Department — Peer Review **262-523-2425** Peer-to-peer reviews must be conducted within two business days of the denial.

If you have questions about...	Contact
Member Services	For member grievances and appeals, interpreter services, personal information changes: Phone: **855-690-7800** TTY: **711** Hours: Monday to Friday, 8 a.m. to 5 p.m. After hours, call the 24/7 Nurse Line: **855-690-7800** Spanish: **800-855-2884** TTY: **711** Hours: 24 hours a day, 7 days a week Written correspondence: Anthem Blue Cross and Blue Shield Central Appeals Processing P.O. Box 62429 Virginia Beach, VA 23466-2429
Verify member eligibility	Verify eligibility through ForwardHealth or Anthem. ForwardHealth: • Phone: **800-947-9627** • Call automated voice response phone: **800-947-3544** • Hours: 24 hours a day, 7 days a week • Website: **www.forwardhealth.wi.gov** Anthem: To check a member's eligibility from Availity **http://www.Availity.com**, use the Patient Registration to access Eligibility and Benefits Inquiry. Provider Services phone: **855-558-1443** • Hours: Monday to Friday, 8 a.m. to 5 p.m. • Prior authorization/notification request: Through Availity select the **Patient Registration** tab to access *Authorizations & Referrals.* • Via fax: **800-964-3627**
Pharmacy questions and prescriptions	ForwardHealth Website: **www.forwardhealth.wi.gov** Providers: Phone: **800-947-9627** Hours: Monday to Friday, 7 a.m. to 6 p.m. Members: Phone: **800-362-3002** Hours: Monday to Friday, 8 a.m. to 6 p.m.

If you have questions about...	Contact
Precertification: Behavioral health	All requests for Prior Authorizations should be submitted online through Availity at **http://www.Availity.com**. From Availity's home page select the **Patient Registration** tab to access *Authorizations & Referrals*. If you prefer to fax, please use appropriate form posted on **https://providers.anthem.com/WI** Anthem Provider Services Phone: **855-558-1443** TTY: **711**
Precertification: Dental	For dental services information refer to the dental services entry in this table. Breakdown is by county for DentaQuest or ForwardHealth.
Precertification: Medical	All requests for prior authorizations should be submitted online through Availity at **http://www.Availity.com**. From Availity's home page select the **Patient Registration** tab to access *Authorizations & Referrals*. If you prefer to fax, please use appropriate form posted on **https://providers.anthem.com/WI**. Anthem Provider Services Phone: **855-558-1443** TTY: **711** Hours: Monday to Friday, 8 a.m. to 5 p.m.
Precertification: Medical injectable drug	All requests for prior authorizations should be submitted online through Availity at **http://www.Availity.com**. From Availity's home page select the **Patient Registration** tab to access *Authorizations & Referrals*. If you prefer to fax, please use appropriate form posted on **https://providers.anthem.com/WI**. Provider Services Phone: **855-558-1443** Hours: Monday to Friday, 8 a.m. to 5 p.m.
Provider Services	Anthem Provider Services Phone: **855-558-1443** Hours: Monday to Friday, 8 a.m. to 5 p.m.
Transportation Services (nonemergent)	Phone: **866-907-1493** TTY: **711** Hours: Monday to Friday, 7 a.m. to 6 p.m.

If you have questions about...	Contact
Vision Services: March Vision Care*	Phone: **855-516-2724** TTY: **711** Hours: Monday to Friday, 8 a.m. to 5 p.m. Website: **www.marchvisioncare.com**
Maternal and Child Health — WIC Program	For early childhood intervention, call: Phone: **800-722-2295** Hours: 24 hours a day, 7 days a week Website: **www.dhs.wisconsin.gov/wic**

Chapter 4: Covered and noncovered services

To check a member's eligibility and benefits, from **http://www.Availity.com** use the **Patient Registration** tab to access *Eligibility and Benefits Inquiry*.

Chat with Payer: Log onto **http://www.Availity.com**. From Payer Spaces select Chat with Payer
Provider Services: **855-558-1443**

Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.

Covered services

The following grid lists the BadgerCare Plus and Medicaid SSI Program covered services, including notations for services requiring precertification. Because covered benefits periodically change, verify coverage before providing services.

Services	BadgerCare Plus and Medicaid SSI coverage
Ambulatory surgery centers	Coverage of certain surgical procedures and related lab services
Dental Anthem, through its partner DentaQuest, covers dental services for members living in the following counties: Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha. ForwardHealth: Coverage in all other counties is through Wisconsin Medicaid Fee-for-Service.	Full coverage; some dental services require precertification.
Disposable medical supplies (DMS)	Full coverage; some DMS requires precertification.
Durable medical equipment (DME)	Full coverage; all custom-made DME requires precertification, some DME requires precertification
Emergency room	Full coverage
End-stage renal disease (ESRD)	Full coverage
HealthCheck screenings for children	Full coverage of HealthCheck screenings and other services for individuals 20 years and under
Hearing Services	Full coverage
Home care services: home health, private duty nursing (PDN) and personal care service	Full coverage; requires precertification
Hospice	Full coverage
Immunizations	Full coverage
Inpatient hospital	Full coverage; requires precertification
Mental health and substance abuse treatment: inpatient	Full coverage; requires precertification
Mental health and substance abuse treatment: outpatient	Full coverage; some outpatient services require precertification
Mental health and substance abuse treatment: day treatment	Full coverage; requires precertification
Nursing home services	Full coverage; requires precertification
Organ transplants	Requires precertification; cornea and kidney transplants are covered by Anthem. Other transplants may be covered by ForwardHealth. Please call Anthem Provider Services.
Outpatient hospital	Full coverage; some services require precertification.

Services	BadgerCare Plus and Medicaid SSI coverage
Physical therapy, occupational therapy, speech, and language pathology therapy	**833-775-1959**
Podiatry	Full coverage
Prenatal/maternity care	Full coverage

Reproductive health service: family planning services	Full coverage (exceptions listed below)
	Does not cover:
	• Infertility treatments
	• Reversal of voluntary sterilization
	• Surrogate parenting and related services including but not limited to:
	  ○ Artificial insemination
	  ○ Obstetrical care
	  ○ Labor or delivery
	  ○ Prescription and over-the-counter drugs

Prescription drugs (covered by ForwardHealth)	Members may fill prescriptions at any pharmacy that will accept the ForwardHealth ID card.
Radiology services	Full coverage; requires precertification is required through Carelon Medical Benefits Management, Inc.* Carelon contact number —**833-775-1959**
Transportation: ambulance	Full coverage of emergency transportation; nonemergency transportation is covered by ForwardHealth.
Vision Services: Contact March Vision	Full coverage including eyeglass frames, lenses, or medically necessary contact lenses

Noncovered services

Anthem does not cover:

- Care provided outside the United States, Canada, and Mexico, including emergency services:
  - Anthem reimburses for emergency services provided to members in Canada and Mexico; however, payment for such services must be made to a financial institution or entity located within the United States. Nonemergency services in Canada or Mexico may be covered by Anthem per precertification policies, provided the financial institution receiving payment is located within the United States.
- Cosmetic surgery, including tattoo removal and ear lobe repair.
- Experimental or investigational procedures.
- Services that are not medically necessary.
- Surgery or drugs to enhance fertility.

Noncovered services also include any instance when the precertification for a service was not granted, or the service was provided before precertification was given.

Services requiring precertification

Precertification is always required for some categories of services, including inpatient hospital services and durable medical equipment rentals. To determine if a specific outpatient service requires precertification, enter the CPT code in our precertification tool online at **https://providers.anthem.com/WI**, use the **Claims** tab to access the Precertification Lookup Tool. Providers can also access the Precertification Lookup Tool through **http://www.Availity.com**. From Payer Spaces, select this payer to access the Precertification Look Up Tool application.

Dental services

Dental services are provided by two different healthcare entities, depending on where the member lives:

Coverage	Dental services	Contact number
Dental coverage for the following counties: Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha	DentaQuest	Provider Line: **855-453-5287**
Dental coverage for all other counties	ForwardHealth	**800-947-9627**

Vision services

Anthem contracts with March Vision Care to provide covered routine vision services. Anthem covers the following services when performed by a March Vision Care contracted provider or with precertification from March Vision Care by an out of network provider:

- Routine vision service
- Eyeglasses

To arrange for vision services, call March Vision Care: **855-516-2724**

Nonemergency transportation services

Nonemergency transportation is a benefit provided by ForwardHealth to Anthem members enrolled in BadgerCare Plus and Medicaid SSI. These services include bus and taxi rides for members needing help getting to medical appointments as well as special vehicle transportation for Anthem members in wheelchairs. Routine rides must be scheduled at least two business days prior to your health are appointment. Same day rides can be scheduled within three hours if you have an urgent need. Phone: **866-907-1493**

State-covered services

Some health services are not covered by Anthem and instead are covered under ForwardHealth. State-covered services include:

- Adaptive behavior assessment and treatment (Autism)
- Chiropractic services
- Community support program services
- Comprehensive community services
- Organ transplants (other than cornea and kidney)
- Pharmacy (prescription drugs and some over-the-counter medications. Members may fill their prescriptions by presenting their ForwardHealth identification ID card to any pharmacy in the BadgerCare Plus network)
- Prenatal care coordination
- Targeted case management
- Tuberculosis services

For more information on state-covered services, contact ForwardHealth: **800-947-3544**.
Website: **www.forwardhealth.wi.gov**

Telehealth

Telehealth enables a provider who is located at a distant site to render the service remotely to a member located at an originating site using a combination of interactive video, audio, and externally acquired images through a networking environment.
Source: WI ForwardHealth Online Handbook. Topic #510 Telehealth.

Telehealth means a practice of healthcare delivery, diagnosis, consultation, treatment, or transfer of medically relevant data by means of audio, video, or data communications that are used either during a patient visit or a consultation or are used to transfer medically relevant data about a patient. Telehealth does not include communications delivered solely by audio-only telephone, facsimile machine, or electronic mail unless the department specifies otherwise by rule.
Source: WI Statute Sec. 49.45 (61). (Senate Bill 380 – 2019 Session)

Telehealth can connect a provider's office to a **specialty center** by:
Live video consult: The PCP and specialist meet at the same time using *HIPAA* compliant video conferencing technology.
Telehealth offers multiple benefits to providers and members:

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

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

Service Standards

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

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

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

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

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

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

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

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

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

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

Electronic Billing/Encounter Coding — The telehealth provider will submit Virtual Visit encounters or claims with proper coding as part of its existing encounter submission process.

Eligibility Verification — The telehealth provider will use existing eligibility validation methods to confirm Virtual Visit benefits.

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

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

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

The authorized originating sites are:
Any originating site. However, only the following originating sites will be eligible for a facility fee reimbursement:

- Hospitals, including emergency departments
- Office/clinic
- Skilled nursing facility

Authorized distant site providers include:

- Audiologists
- Individual mental health and substance abuse practitioners not in a facility certified by the DQA
- Nurse midwives
- Nurse practitioners
- Ph.D. psychologists
- Physician assistants
- Physicians
- Psychiatrists
- Professionals providing services in mental health or substance abuse programs certified by the DQA

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

Chapter 5: Member eligibility

To check a member's eligibility and benefits, from **http://www.Availity.com** use the **Patient Registration** tab to access *Eligibility and Benefits Inquiry*.

Chat with Payer: Log onto Availity.com. From Payer Spaces select Chat with Payer
Provider Services: **855-558-1443**
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.
Website: **https://providers.anthem.com/WI**
ForwardHealth WiCall: **800-947-3544**
Hours of operation: 24 hours a day, 7 days a week
ForwardHealth website: **www.forwardhealth.wi.gov**

Overview

Anthem members enrolled in BadgerCare Plus and Medicaid SSI should carry and present a current ForwardHealth ID card when seeking services. The ForwardHealth ID card is issued by the state of Wisconsin. A member's BadgerCare Plus enrollment and other health insurance must be verified by providers before services are delivered. Because eligibility can change, verify eligibility at each visit. Remember, claims submitted for services rendered to noneligible members are not eligible for payment. To prevent fraud and abuse, providers should confirm the identity of the person presenting the ID card.

Verifying member eligibility

Providers can verify member eligibility as follows:

- Contact ForwardHealth for real-time member enrollment and eligibility verification for all ForwardHealth programs 24 hours a day, 7 days a week or use the website to determine the member's specific benefit plan and coverage:
    - ForwardHealth WiCall automated voice response: **800-947-3544** (24 hours a day, 7 days a week)
    - ForwardHealth website: **www.forwardhealth.wi.gov**
- To check a member's eligibility and benefits, from Availity.com use the Patient Registration tab to access Eligibility and Benefits Inquiry.
- Provider Services:
    - Phone: **855-558-1443** (Monday to Friday, 8 a.m. to 5 p.m.)

ForwardHealth member ID card

The ForwardHealth member ID card includes the member's name, 10-digit member ID, magnetic stripe, signature panel and the Member Services phone number. The card also has a unique, 16-digit card number on the front for internal program use. On the back of the card, there's a toll-free number, which is for member use only, and an address to return a lost card to ForwardHealth. For more information about verification of ForwardHealth member enrollment and ID cards, providers may refer to the "Member Information" section of the ForwardHealth provider manual.

Note: Members do not receive a new ForwardHealth card if they're enrolled in a state-contracted MCO or change from one MCO to another. Providers should verify enrollment with the EVS every time they see a member to ensure they have the most current managed care enrollment information.

Anthem member ID card

The front of the Anthem member ID card includes the Anthem ID number (which always begins with the alpha prefix ZRA), the name and phone number of the member's PCP, and the PCP effective date. The back includes the mailing address for paper claims and important phone numbers.

Chapter 6: Medical management

Medical Management: **855-558-1443**
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.

Overview

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

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

- Benefit coverage
- Established criteria
- Community standards of care

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

- Precertifications
- Concurrent/continued stay reviews
- Post-service reviews

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

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

After a case has been reviewed, decisions and notification time frames will be given for service approval, modification, and denial.

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

If you disagree with a decision and want to discuss the decision with the physician reviewer, call the Medical Management department: **262-523-2425**. This call must be made within two business days of the denial to set up a peer to peer. You may also send in additional clinical information (labeled "Reconsideration") within two business days of the denial to have decision reconsidered by a physician reviewer.

You may download a copy of the guidelines from the provider website at **https://providers.anthem.com/WI**. To request a hard copy, call Provider Services at **855-558-1443**, and we will gladly mail one to you.

Services requiring precertification

To determine if an outpatient service requires prior authorization , select the Precertification Look Up Tool link on the *Precertification* page of the provider website at **https://providers.anthem.com/WI/pages/precertification-forms.aspx**.

Please note: Emergency hospital admissions and observation admissions do not require precertification. However, notification is required within 24 hours or the next business day if member is going to be inpatient status.

Requesting precertification

You may contact us with questions or precertification requests regarding healthcare services including:

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

Online / digital Authorization Requests

Submitting authorizations online through the Availity Authorization application is the preferred method for submitting preauthorization requests. Digital authorization submissions are the most efficient way to request inpatient and outpatient medical or behavioral health services for our members. Use the Availity Authorization application to make inquiries about a previously submitted request, regardless of how they were submitted (manually or digitally).

Submitting digital precertifications:

- Eliminates the need to fax. You can attach detailed text, photo images and other documentation directly to your submission.
- Makes inquiries on previously submitted requests faster than calling or chatting.
- Gives you instant accessibility from almost anywhere, including after business hours.
- Provides a complete view of all utilization management requests with real-time status updates, including email notifications if desired from a single Dashboard view. Enables real-time results for common procedures with immediate decisions.
- Enhances analytics that can provide immediate decisions on authorizations for certain higher levels of care.
- Increases efficiency and faster decisioning.

To request and follow up on an authorization, logon to **Availity.com**. Use the **Patient Registration** tab and select *Authorizations and Referrals*. Online authorization requests are **not** currently available for:

- Transplant services
- Services administered by vendors, such as Carelon. For these requests, follow the same preauthorization process you use today.

Phone or fax

You can also request precertification for medical or behavioral health concerns or report a medical admission by contacting the Medical Management department at **855-558-1443** or faxing to **800-964-3627**.

Staff will identify themselves by name, title, or organization name.

The Medical Management department will return calls:

- On the same day when received during normal business hours.
- On the next business day when received after normal business hours.
- Within 24 hours for all routine requests.

Providers may fax the Medical Management department and include requests for:

- Urgent or expedited pre-service reviews.
- Nonurgent concurrent or continued stay reviews.

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

You may call Provider Services at **855-558-1443**, 24 hours a day, 7 days a week.

To request precertification or report a medical admission, call the Medical Management department and have the following information ready:

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

All providers, including physicians, hospitals, and ancillary providers, are required to provide information to the Medical Management department. Obtain a separate precertification for each service requiring approval. Precertification is necessary whether an in-network or out-of-network provider performs the service. For the latest information about which services require precertification, go to **https://providers.anthem.com/WI** > Precertification.

Requests with insufficient clinical information

When the Medical Management department receives requests with insufficient clinical information, we will contact the provider with a request for the information reasonably necessary to determine medical necessity. We will make one final attempt to contact the requesting provider for a total of two requests to obtain this additional information. If we do not receive a response, the request will be reviewed with the information originally submitted and sent to the medical director for denial. A denial letter will be sent to both the member, provider, and facility, if applicable.

Utilization management appeals

When Anthem denies a request, both the member and provider receive a *Notice of Action* denial letter. To file an appeal, the member's authorized representative or the provider acting on behalf of the member must notify us within 60 calendar days of the date on the *Notice of Action* denial letter.

Utilization Management appeals must be filed in writing and mailed to:

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

Urgent requests

For urgent requests, the Medical Management department completes a pre-service review within 72 hours from receipt of the clinical information. Generally speaking, the provider is responsible for contacting us to request pre-service review for both professional and institutional services. However, the hospital or ancillary provider also should contact Anthem to verify pre-service review status for all non-urgent care before rendering services. The health plan does reserve the right to determine if the request meets the definition of urgent criteria. Urgent definition: Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away. If the request is deemed as not meeting the urgent definition, the request can and will be de-expedited and reviewed in time/date order that it was received.

Emergency medical services

Anthem does not require precertification for treatment of emergency medical conditions. In the event of an emergency, members may access emergency services 24 hours a day, 7 days a week. If the emergency room visit results in the member's admission to the hospital, providers must contact Anthem within 24 hours or the next business day.

Emergency stabilization and post-stabilization

The emergency department's treating provider determines the services needed to stabilize the member's emergency medical condition. After the member is stabilized, the emergency department's provider must contact the member's PCP for authorization of further services. If the PCP does not respond within one hour, the necessary 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 and file the chart in the member's permanent medical record.
- Contact the member.
- Schedule a follow-up office visit or a specialist referral, if appropriate.

Concurrent reviews

Concurrent reviews: Hospital inpatient admissions

Hospitals must notify us of inpatient admissions within 24 hours of admission or by the next business day. Notify us about the following admissions:

- Behavioral health
- Medical care
- Substance abuse

After notification of an inpatient admission is received, we will send a request for clinical information supporting the admission's medical necessity. Evidence-based criteria are used to determine medical necessity and the appropriate level of care.

Concurrent reviews: Clinical information for continued-stay review

When a member's hospital stay is expected to exceed the number of days authorized during pre-service review, or when the inpatient stay did not have pre-service review, the hospital must contact us for continued stay review. We require clinical reviews on all members admitted as inpatients to:

- Acute care hospitals.
- Intermediate facilities.
- Skilled nursing facilities.

We perform these reviews to assess medical necessity and determine whether the facility and level-of-care are appropriate. Anthem identifies members admitted as inpatients by:

- Facilities, providers, members, and/or member's representatives reporting admissions.
- Claims submitted for services rendered without authorization.
- Pre-service authorization requests for inpatient care.

The Medical Management department will complete a continued-stay inpatient review within 72 hours of receipt of clinical information or sooner, consistent with the member's medical condition. Medical management nurses will request clinical information from the hospital on the same day as notification regarding the member's admission and/or continued stay. Providers should notify the health plan of an inpatient admission within 24 hours of the admission.

If the information meets medical necessity review criteria, we will approve the request within 72 hours of receipt of the information. We will send requests that do not meet medical policy guidelines to the physician adviser or medical director for further review. In addition to notifying providers of the decision within 72 hours, we will send written notification of denial or modification of the request to the member and the requesting provider.

Concurrent reviews: Second opinions

The following are important guidelines regarding obtaining a second opinion:

- The second opinion must be given by an appropriately qualified healthcare professional.
- The second opinion must come from a provider of the same specialty as the first provider.
- The secondary specialist may be selected by the member.
- When an appropriate specialist is not within Anthem's network, Anthem will authorize a second opinion by a qualified provider outside of the network upon request by the member or provider.

A second opinion is a covered service, offered at no cost to our members.

Denial of service

Only a medical or behavioral health provider with an active professional license or certification may deny services for lack of medical necessity including the denial of:

- Procedures
- Hospitalization
- Equipment

Nonmedical necessity determinations refer to services such as authorization requests where Utilization Management approval is sought. For example, a member is an inpatient for three days, and the provider requests an additional stay that is rejected as medically unnecessary. Nonmedical necessity determinations are reviewed by the health plan's Utilization Management team, and the final determination is made by the health plan's medical director not to cover the services.

When a request is determined to be not medically necessary, the requesting provider will be notified of the decision, the process for appeal and how to reach the reviewing physician for peer-to-peer discussion of the case.

To contact the physician clinical reviewers to discuss a decision, providers may call the Medical Management department: **262-523-2425**. Peer to peers (phone calls) or reconsiderations (additional clinical faxed in) may be submitted/scheduled within two business days from the date of the denial.

Referrals to specialists

The Medical Management department is available to assist providers in identifying a network specialist and/or arranging for specialist care. Specialists must be Wisconsin Medicaid certified, whether in-network or out-of-network.

Authorization is:

- Required when referring a member to an out-of-network specialist.
- Required for an out-of-network referral when an in-network specialist is not available in the geographical area.
- Not required if referring a member to an in-network specialist for consultation or a nonsurgical course of treatment.

Provider responsibilities include documenting referrals in the member's chart and requesting the specialist to provide updates about diagnosis and treatment.

Please note: Obtain a precertification approval number before referring members to an out-of-network provider. For out-of-network providers, we require precertification for the initial consultation and each subsequent service.

Additional services: Behavioral health

Anthem is committed to providing a continuum of care management from initial contact to coordination of care and interventions. Our behavioral health case managers work closely with our medical case managers to support the behavioral health services needed by our members. The key to this support system is Anthem's three-tiered system:

- Tier one: Member Services and outreach calls to members
- Tier two: Increased interaction with members to assist with provider referrals, problem-solving and removing obstacles to receiving treatment
- Tier three: Intensive case management offering interventions on an episodic basis or triggered by a long length of stay, medical and behavioral health comorbidity, and/or multiple admissions

Contact the Medical Management department for more information and precertification of all behavioral health, facility-based care including but not limited to:

- Inpatient admissions
- Intensive outpatient program
- Emergency department visits
- Partial hospitalization programs
- Psychological testing
- Some outpatient services

Please have the following information ready when requesting a referral:

- Clinical information supporting the request
- Diagnosis with ICD code
- First date of outpatient service or date of hospital admission
- Procedure with CPT and/or HCPCS code(s)
- Specialist or attending provider name

Additional services: Vision care

Members have access to basic vision care services through March Vision Services. Providers may contact March Vision Services **855-516-2724**

Additional services: Dental care

DentaQuest provides dental services to members in Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha counties only. To obtain precertification of dental services for members in these counties, contact DentaQuest. Medically necessary inpatient or outpatient services rendered during the performance of a dental procedure may be covered. Phone: **855-453-5287**

To obtain precertification of dental services for members in all other counties, please contact ForwardHealth Provider Services. Medically necessary inpatient or outpatient services rendered during the performance of a dental procedure may be covered. Phone: **800-947-9267**

Chapter 7: Health services programs

Chat with Payer: Log onto **http://www.Availity.com**. From Payer Spaces select Chat with Payer
Provider Services: **855-558-1443**
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.

Overview

At Anthem, we are proud of our joint efforts with the community-based health organizations to maximize healthcare services for our members. These service organizations include:

- Bureau of Milwaukee Child Welfare
- Local health departments
- Prenatal care coordination agencies

Our approach is collaborative, results-oriented, community-based, and member-centered. We encourage providers to work with these community organizations to coordinate care, ensure continuity, and provide culturally appropriate services to our members enrolled in BadgerCare Plus and Medicaid SSI. Our agreements offer clear guidelines for sharing clinical data that can help our members lead healthier lives.

The intent of our collaboration with our community partners is to supplement providers' treatment plans. When combined with our own health services programs, they can improve our members' overall health by informing, educating, and encouraging self-care. The targeted programs are divided into four categories:

- Preventive care programs, including New Baby, New Life℠ for perinatal members and their newborns and HealthCheck, a health screening and immunization program for members under the age of 21
- Health management programs, which promote knowledge and encourage self-care for specific medical conditions and chronic disease, including diabetes, asthma and heart disease
- Health education, including the 24/7 NurseLine, a phone line available 24 hours a day, 7 days a week for all health-related questions
- Telehealth, a unique healthcare delivery method utilizing computers and videoconferencing equipment to connect providers to specialists in different locations

HealthCheck

HealthCheck is Wisconsin's name for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. HealthCheck is a preventive healthcare program for all Anthem members enrolled in BadgerCare Plus and Medicaid SSI who are under the age of 21 and meet the physical exam requirements for programs such as:

- Head Start.
- Supplemental Nutrition Program for Women, Infants and Children (WIC).
- School physicals.

To be considered a comprehensive HealthCheck screen, the provider must assess and document the following:

- Complete health and developmental history, including anticipatory guidance
- Comprehensive unclothed physical exam
- Age-appropriate vision screening exam
- Age-appropriate hearing screening exam
- Oral assessment plus referral to a dentist beginning at 1 year of age
- Appropriate immunizations according to age and health history
- Appropriate laboratory tests, including blood lead level testing when age-appropriate

HealthCheck: Provider target levels

State of Wisconsin and federal requirements provide HealthCheck guidelines to which providers must adhere. Providers also must achieve a threshold of at least 80% of allowable screenings. For more information, see the Vaccines and Immunizations page on the Centers for Disease Control and Prevention (CDC) website: **www.cdc.gov**.

Comprehensive HealthCheck screenings limits for each member in a consecutive 12-month period are as follows:

- Birth to first birthday: six screenings
- First to second birthday: three screenings
- Second to third birthday: two screenings
- Third to sixth birthday: one screening/year
- Sixth to 21st birthday: one screening every other year

Wisconsin's ForwardHealth allows one screening per year.

We'll provide you with complete information regarding the percentage of allowable HealthCheck screenings your clinic has completed. ForwardHealth has developed and makes available free-of-charge forms that meet the documentation requirements of the program. Use of these forms is optional, and providers and clinics that have developed their own documentation systems may continue to do so. The provider's documentation must demonstrate that all areas listed in the **Preventive care: HealthCheck** section have been assessed and are included in the member's medical record. For more information, go to ForwardHealth website at **www.forwardhealth.wi.gov** and:

1. Select Providers.
2. Under *Quick Links*, select **Forms**.
3. Scroll down to the *HealthCheck Forms* section and select the form you need.

HealthCheck: Provider responsibilities

- Document all healthcare screenings, immunizations, procedures, health education and counseling in the member's medical record.
- Refer members to dentists, optometrists, ophthalmologists or other specialists as needed. Document all referrals in the member's medical record.
- Schedule preventive care appointments for members under the age of 21 following the American Academy of Pediatrics (AAP) periodicity schedule. For more information, go to the AAP website: **www.healthychildren.org**.
- Provide immunizations as needed and according to the schedule established by the Advisory Committee on Immunization Practices (ACIP), American Academy of Family Physicians (AAFP) and the AAP. An instant childhood immunization schedule is available on the CDC website: **www.cdc.gov**.
- Refer members to the county health department and maintain a record of the child's immunization status if the provider does not routinely administer immunizations as part of his or her practice.

If the parent or guardian of a BadgerCare Plus or Medicaid SSI member requests a comprehensive HealthCheck examination, the examination must be provided within the following time frames:

- Within 30 days: If the member is under 1 year of age and the screening is due within 30 days. If the screening is not due within 30 days, the provider must schedule the appointment in accordance with the periodicity schedule.
- Within 60 days: If the member is over 1 year of age and the screening is due within 60 days. If the screening is not due within 60 days, the provider must schedule the appointment in accordance with the periodicity schedule.

Please note: As a condition of certification as a provider for BadgerCare Plus and Medicaid SSI members, Anthem must share member immunization status with local health departments and other nonprofit HealthCheck providers upon request and without member authorization. The Wisconsin Department of Health Services (DHS) also requires that local health departments and other nonprofit HealthCheck providers share the same information with Anthem upon request. This provision ensures proper coordination of immunizations and prevents duplication of services. In addition, Anthem requires that the majority of network providers have a signed user agreement with the Wisconsin Immunization Registry (WIR).

HealthCheck: Anthem reminders

Anthem has developed intervention strategies to keep members up-to-date with the HealthCheck program. These intervention strategies include the following reminders:

- Immunization reminder calls at 3, 6, 9, 12, 15 and 18 months of age
- Preventive care calls to members ages 2 to 20 during their birth months

Please note: For ForwardHealth and Anthem to recognize and reimburse the visit as a complete HealthCheck screening or exam, providers must assess and document all age-specific components.

New Baby, New Life℠

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

When it comes to 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 complex care management support for highest risk members
- 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 allows 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 care management approach for our highest risk pregnant members; however, it does serve as a supplementary tool to extend our health education outreach. The goal of the expanded outreach is to ensure maternity education is available to all perinatal members and help Anthem to identify members who experience a change in risk acuity throughout the perinatal period.

We request notification of pregnancy at the first prenatal visit and notification of delivery following birth. You may choose to complete the notification of pregnancy and delivery in Availity Essentials or fax the forms to Anthem at 1-800-964-3627.

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

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

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

For more information about the New Baby, New Life program or the digital app, reach out to your OB Practice Consultant or Provider Services at **855-558-1443**, or refer to our website at **https://providers.anthem.com/wisconsin-provider/patient-care/maternal-child-services**.

Neonatal Intensive Care Unit (NICU) Case Management

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

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

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

- Helping parents engage with hospital-based support programs
- Facilitating parent screenings for potential PTSD

- Connecting parents with behavioral health program resources and community support as needed
- Actively asking for their feedback on the provided resources and how an increased awareness of PTSD has helped

If you have a patient in your care that would benefit from participating in our NICU Care Management program, please call us at **855-558-1443**. Members can also call our 24/7 NurseLine at **800-690-7800**, 24 hours a day, 7 days a week.

Condition Care

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

Services include:

- A holistic, member-centric approach to Condition Care, focusing on the needs of the member through telephonic and community-based resources.
- Motivational interviewing techniques used in conjunction with member self-empowerment.
- The ability to manage more than one disease to meet the changing healthcare needs of our member population.

Who is eligible?

Members diagnosed with one or more of the conditions listed below are eligible for Condition Care services:

- Asthma
- Bipolar disorder
- Chronic obstructive pulmonary disorder
- Congestive heart failure
- Coronary artery disease
- Diabetes
- HIV/AIDS
- Hypertension
- Child/adolescent major depressive disorder
- Major depressive disorder
- Schizophrenia
- Substance abuse disorder

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

Program features:

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

Anthem Condition Care clinical practice guidelines are located at **https://providers.anthem.com/WI**. A copy of the guidelines can be printed from the website, or you can contact Provider Services at **855-558-1443** to receive a copy.

As a valued provider, we welcome your referrals of patients who can benefit from additional education and case management support. Our case managers will work collaboratively with you to obtain your input in the development of care plans. Members identified for participation in any of the programs are assessed and risk

stratified based on the severity of their disease. They are provided with continuous education on self-management concepts, which include primary prevention, coaching related to healthy behaviors and compliance/monitoring as well as case/care management for high-risk members. Providers are given telephonic and/or written updates regarding patient status and progress.

Condition care provider rights and responsibilities

The provider has the right to:

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

Hours of operation

Anthem case managers are registered nurses and are available Monday through Friday from 8:30 a.m. to 5:30 p.m. local time. Confidential voicemail is available 24 hours a day.

Contact information

Call **888-830-4300** to reach a case manager. Additional information about condition care can be obtained by visiting **https://providers.anthem.com/WI** and selecting Patient Care > Condition Care.

Women, Infants and Children Program

The special supplemental nutrition program for Women, Infants and Children (WIC) serves to safeguard the health of low-income women, infants, and children up to age 5 who are at nutritional risk. WIC provides nutritious foods to supplement diets, information on healthy eating and referrals to healthcare.

Providers are responsible for:

- Identifying if a member is eligible for WIC and referring that member to the WIC program.
- Informing and educating eligible members of the availability of WIC services, including availability of food vouchers, nutrition education classes and community referrals.
- Providing written materials about WIC services in the provider's office.

Member eligibility is contingent upon meeting WIC's nutritional risk requirement, as well as the following:

- A woman who is pregnant, up to six weeks after the birth
- A woman who is breastfeeding, up to the infant's first birthday
- An infant, up to the infant's first birthday
- A child at nutritional risk, up to the child's fifth birthday

The nutritional risk requirement means that an individual has medically-based or dietary-based conditions. Examples are as follows:

- Medically based conditions include anemia, underweight or a history of poor pregnancy outcomes
- Dietary-based conditions include a failure to meet dietary guidelines or inappropriate nutrition practices

For more information about the WIC program, go to the WIC website: **www.dhs.wisconsin.gov/wic**.

24/7 NurseLine

We recognize that questions about healthcare prevention and management do not always come up during office hours. The 24/7 NurseLine, a phone line staffed by registered nurses, provides a powerful provider support system and is a component of after-hours care. The 24/7 NurseLine allows members to closely monitor and manage their own health by giving members the ability to ask questions whenever the need arises. The 24/7 NurseLine is available 24 hours a day, 7 days a week.
Phone: **855-690-7800**
TTY: **711**
Members may contact the 24/7 NurseLine for:

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

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

Pharmacy lock-in initiative

In conjunction with our initiative to reduce inappropriate use of the emergency room (ER), a lock-in program has been developed to decrease inappropriate use of the ER for pain management and drug-seeking behavior. Members may choose a primary prescriber and a pharmacy; Anthem will assist the member in finding a prescriber if needed. If the member does not do this, they're assigned a prescriber and pharmacy by the state. Providers assigned to the member receive information on members who are assigned to the lock-in program.

Smoking Cessation

Anthem supports the National Cancer Institute's health education program for members who want to quit smoking. The Smoking Cessation program's goals are to:

- Assist members in improving their health status and quality of life by becoming more actively involved in their own care.
- Encourage members to quit smoking.
- Offer members resources and education as a means of supporting tobacco cessation efforts.

The National Cancer Institute has developed a booklet called Clearing the Air. The booklet provides tips to support tobacco cessation by identifying available resources and offering tools for quitting such as:

- Winning strategies of successful quitters.
- Coping skills for fighting the urge to smoke.
- Strategies for success after a relapse.
- National Quit Line contact information.

National Cancer Society Smoking Quit Line: **877-44U-QUIT (877-448-7848)**

After enrollment, a member may request the Clearing the Air booklet by using the contact information provided in the plan's welcome packet, contacting our 24/7 NurseLine, or talking to Medical Management nurses or social workers. The booklet is also available to download from the following websites:
National Cancer Institute: **https://pubs.cancer.gov**
Smokefree.gov: **smokefree.gov**

Provider assessment of tobacco use

The following are guidelines providers should use to help members quit smoking:

- Assess members' smoking status and offer advice about quitting.

- Use the state’s online Notification of Pregnancy form as a way to notify us, through the state, of pregnant women who smoke. Women are more likely to quit smoking during pregnancy.
- Offer members resources to stop smoking, including the Clearing the Air program information from the National Cancer Institute.
- Refer members to Wisconsin's help line to stop smoking: **800-QUIT-NOW (800-784-8669)**.

Tobacco use disorder is one of the key initiatives the state of Wisconsin is focusing on for HMO patients. The state is measuring the percentage of BadgerCare Plus members who are 12 years of age and older and identified as tobacco users receiving tobacco counseling.

The goals are for patients with tobacco use disorder to receive tobacco counseling and be identified through the claims submission process. Behavioral health and medical services providers should use the appropriate CPT and diagnosis code for their provider type.

SSI Enhanced Care Program

To serve the special healthcare needs of the Medicaid SSI population, Anthem has developed a team-based, member-centric care management program that coordinates and integrates all aspects of members’ healthcare. Anthem’s Care Management team conducts a health needs assessment of each member to assist in developing a comprehensive care plan, using a member-centric, culturally competent, and collaborative approach to care. Team members include licensed healthcare professionals with expertise across medical, behavioral health, and social determinants of health. The team coordinates with the member’s PCP, medical and behavioral health specialists, dentists, and other community resources as driven by the member’s care plan.

Chapter 8: Claims and billing

Chat with Payer: Log onto **Availity.com**. From Payer Spaces select Chat with Payer
Provider Services: **855-558-1443**
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.

Overview

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

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

Providers can check claim status through Availity at **Availity.com** with their username and password. Providers will need to be registered with Availity to access the secure portion of the website. Once signed up, you can log in to a single account and perform numerous administrative tasks for patients covered by us or other selected payers. Providers may also access Availity from our website. When viewing the status of a claim on Availity, there may be options available to submit medical records or an itemized bill or dispute the claim.

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

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

Submitting clean claims

Claims submitted correctly the first time are called *clean*, meaning that all required fields have been filled in and that the correct form was used for the specific type of service provided.

A claim submitted with incomplete or invalid information may be returned. If you use Electronic Data Interchange (EDI), claims will be returned for incomplete or invalid information. Claims also may be returned if they are not submitted with the proper *HIPAA*-compliant code set. In each case, a response report will be sent to you or your EDI vendor, and the claim will not be sent through for payment. You and your staff are responsible for working with your EDI vendor to ensure that *rejected* claims are corrected and resubmitted.

Generally, there are two types of forms you'll need for reimbursement:

- *CMS-1500* for professional services
- *CMS-1450 (UB-04*) for institutional services

CMS forms are located at **www.cms.gov**. These forms are available in both electronic and hard copy/paper formats.

Please note: Using the wrong form or not filling out the form correctly or completely may cause the claim to be returned, resulting in processing and payment delays.

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

Claims submission methods

There are two methods for submitting a claim:

- Electronically though EDI
- Digitally through **Availity.com**
- Paper or hard copy

Availity offers a variety of online applications to help you reduce administrative costs by eliminating paperwork and phone calls. You will need to sign up to access Availity.com. Once signed up, you can log in to a single account and perform most administrative tasks digitally for BadgerCare Plus or Medicaid SSI patients covered by Anthem or by other payers.

Single claim submissions can be submitted to Availity by selecting the **Claims & Payment** tab. For more information about Availity such as how to register, training opportunities and more, visit **https://availity.com/Essentials-Portal-Registration**.

If additional information and documentation is needed to process your claim, submit that information digitally through the Claims Status application on **Availity.com**. From the **Claims & Payments** tab select **Claims Status**, locate the claim, and use the **Submit Attachments** button to attach your documents directly to your claim.

Electronic claims

Anthem uses Availity 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 to do business.

Use Availity for the following EDI transactions:

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

Availity's EDI submission options:

- EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software). To register for direct EDI transmissions, from **Availity.com** select the **Claims & Payments** tab to access EDI Clearinghouse.
- Use your existing vendor for your EDI transactions (work with your vendor to ensure connection to the Availity EDI gateway)

Availity EDI Payer IDs:

- Professional: 00950
- Institutional: 00450

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

EDI Response Reports

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

Please note: A front-end editing process may occur with your contracted EDI vendor or clearinghouse to catch mistakes. If claims are not in a *HIPAA*-compliant transaction code set, your claim may be *errored out* by your EDI vendor. An error report will be sent to you, and your claim will not be sent through for payment. Review the error report, make the necessary changes and file again. Claims from providers who are not Wisconsin Medicaid-certified will be rejected during the front-end editing.

EDI submission for corrected claims

For corrected electronic claims the following frequency code:

- 7 – Replacement of Prior Claim

EDI segments required:

- Loop 2300- CLM - Claim frequency code
- Loop 2300 - REF - Original claim number

Please work with your vendor on how to submit corrected claims.

Paper claims

Manual process can cause delays in claims processing. Submitting your claims digitally through Availity.com either through the Claims & Payments tab or EDI for the fastest claim submission experience. If you must submit paper claims, they must be legible and submitted in the proper format. Anthem accepts black and white paper claim forms as well as original red and white paper claim forms.

Follow these requirements to speed processing and prevent delays:

- Use the correct form.
- Use black or blue ink. Do not use red ink because the scanner may not be able to read red ink.
- Use the Remarks field for messages.
- Do not stamp or write over boxes on the claim form.
- Send the original claim form to Anthem and retain a copy for your records.
- Do not staple original claims together; Anthem will consider the second claim as an attachment and not an original claim to be processed separately.
- Remove all perforated sides from the form. To help our equipment scan accurately, leave a quarter-inch border on the left and right sides of the form after removing perforated sides.
- Type information within the designated field. Be sure the type falls completely within the text space and is properly aligned.
- Do not highlight any fields on the claim forms or attachments. Highlighting makes it more difficult to create a clear electronic copy when the document is scanned.
- If using a dot matrix printer, do not use "draft mode" because the characters generally do not have enough distinction and clarity for the optical scanner to read accurately.

If you submit paper claims, you must include the following provider information:

- Provider name
- Provider billing address, including street, city, and ZIP+4 (P.O. Box is not accepted.)
- Group and rendering provider NPI:
    - Note: Personal care agencies must submit their Medicaid ID.
- Federal provider tax identification number (TIN)

- Anthem's payer identification number (Professional: 00950; Institutional: 00450)

The group/rendering provider taxonomy code is required on all claims.

Mail paper claims to:
Anthem Blue Cross and Blue Shield - Claims
P.O. Box 61010
Virginia Beach, VA 23466-1010

After filing a paper claim, you should receive a response from Anthem within 30 business days after we receive the paper claim. If the claim contains all required information, Anthem enters the claim into the claims system for processing and sends you either a remittance advice or a claims disposition notice when the claim is finalized.

If additional information and documentation is needed to process your claim, submit that information digitally through the *Claims Status* application on **Availity.com**. From the **Claims & Payments** tab select **Claims Status**, locate the claim, and use the **Submit Attachments** button to attach your documents directly to your claim.

National provider identifier

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

NPIs are divided into two types:

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

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

The following websites offer additional NPI information:

- CMS: **Home - Centers for Medicare & Medicaid Services | CMS**
- NPPES: **https://nppes.cms.hhs.gov**
- Workgroup for Electronic Data Interchange: **www.wedi.org**
- National Uniform Claims Committee: **www.nucc.org**

Enrollment in Wisconsin Medicaid

To be reimbursed for services by Anthem, providers must complete Wisconsin Medicaid's provider enrollment process. Providers enroll by completing an online enrollment application using the ForwardHealth website at:
https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Certification/CertificationHomePage.aspx.

Filing limits

Claims filing limits

Claims must be submitted within the contracted filing limit to be considered for payment. Claims submitted after that time period will be denied.

Please note: Anthem is not responsible for a claim never received. If a claim is submitted inaccurately, prolonged periods before resubmission may cause you to miss the filing deadline. Claims must pass basic

edits to be considered received. To avoid missing deadlines, submit clean claims as soon as possible after delivery of service.

Claim forms and filing limits

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

Form	Type to be billed	Time limit to file

CMS-1500 Claim Form	• Physician, physician groups and other professional services
	• Specific ancillary services, including:
	  ○ Audiologists
	  ○ Ambulance
	  ○ Ambulatory surgical center
	  ○ Dialysis
	  ○ Durable medical equipment (DME)
	  ○ Diagnostic imaging centers
	  ○ Hearing aid dispensers
	  ○ Laboratories
	  ○ Mental health and substance abuse clinics
	  ○ Occupational therapy
	  ○ Orthotics
	  ○ Physical therapy
	  ○ Speech therapy
	Some ancillary providers may use a CMS-1450 form if they are ancillary institutional providers. Ancillary charges by a hospital are considered facility charges.
		Submit within 365 days from date of service.

CMS-1450 Claim Form	• Skilled nursing facility (SNF) • Hospitals, hospices, institutions home health services and Personal Care Services	Submit within 365 days from date of service or date of discharge if the services are related to an inpatient stay.

Other filing limits

Action	Details	Time frame
Third-party liability or coordination of benefits (COB)	If the claim has third-party liability, COB or requires submission to a third party before submitting to Anthem, timely filing is counted from the date of the explanation of payment of the other carrier.	Submit within 365 days from date of service or 90 days from the date of the explanation of payment of the other carrier.
Checking claim status	Check claims status by logging onto **Availity.com**. Select the **Claims & Payments** tab to access **Claims Status**. Refer to the **Monitoring Submitted Claims** section of this chapter for details.	
Claim correspondence or corrected claim	If we request additional information or a correction to a claim, a claim follow-up is needed, and you may need to submit a corrected claim.	Return the requested information within 365 days from the date of service

Action	Details	Time frame
Reconsideration Claim appeal (First Level)	Claim Reconsideration (First level) appeals can be submitted digitally through **Availity.com**. From the **Claims & Payments** tab select **Claims Status**. Find your claim and use the Dispute button to file a dispute. Use your Appeals Dashboard to track your dispute. • Provider Services at **855-558-1443** (Monday to Friday, 8 a.m. to 5 p.m.). Anthem Blue Cross and Blue Shield Claim Appeals P.O. Box 61599 Virginia Beach, VA 23466-1599	Submit within 365 days from the date of service.
Formal Claim Dispute (Second Level)	Formal Claim dispute (Second level) can be submitted: • In writing to: Anthem Blue Cross and Blue Shield Claim Appeals P.O. Box 61599 Virginia Beach, VA 23466-1599	Submit within 60 days of the date on the first level reconsideration decision letter.
Provider dispute	We may request additional information on the dispute filed.	Return the requested information within 60 days of the date of the request.

Claims from noncontracted providers

Anthem accepts the following claims from noncontracted providers under certain conditions and within certain time frames:

- Emergency services: 365 days from date of service or discharge date
- Non contracted providers require authorization from Anthem and Medicaid certification from the WI Department of Health Services prior to rendering services except for Emergency services.

Member copayments and balance billing

Providers contracted with Anthem may not balance bill our members, meaning that providers may not collect payment from a member for covered services above the amount Anthem pays to the provider.

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

- Establish that precertification was requested and denied before rendering service.
- Request a review of Anthem's authorization decision.
- Notify the member that the service requires precertification, and Anthem has denied authorization. If out-of-network, the provider also must explain to the member that covered services may be available without cost when provided by an in-network provider. Precertification for out-of-network services is required.
- Inform the member of his or her right to file a grievance if the member disagrees with the decision to deny authorization.

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

- The member accepts responsibility for payment, and the provider and member make payment arrangements for the service.
- If the provider uses a waiver to establish member responsibility for payment, the waiver must meet the following requirements:
    - The waiver is signed only after the member receives appropriate notification and before services are rendered.
    - The waiver does not contain any language or condition to the effect that if authorization is denied, the member is responsible for payment.
    - A waiver must be obtained for each encounter or member visit that falls under the scenario of the noncovered services. Providers may not use nonspecific patient waivers.
    - The waiver must specify the date services were provided and which services fall under the waiver's application.
    - The waiver must show the cost of the services and have a payment plan established.

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

Coordination of benefits (COB)

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

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

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

Subrogation

Anthem follows the state of Wisconsin's subrogation laws as cited in the Administrative Code DHS 106.03(8) – personal injury and workers' compensation claims: If a provider treats a recipient for injuries or illness sustained in an event for which liability may be contested or during the course of employment, the provider may elect to bill Medicaid for services provided without regard to the possible liability of another party or the employer. Alternatively, the provider may elect to seek payment by joining in the recipient's personal injury claim or workers' compensation claim, but in no event may the provider seek payment from both Medicaid and a personal injury or workers' compensation claim. After the provider accepts the Medicaid payment for services provided to the recipient, the provider shall not seek or accept payment from the recipient's personal injury or workers' compensation claim.

Providers must choose which method of payment they will pursue at the time of treatment and submit claims either to Anthem or to the member's personal injury/workers' compensation carrier. The law does not allow providers to submit claims to both carriers. If a provider submits to both carriers, receives payment from both carriers and subsequently sends a refund to Anthem, submission of the refund still could be considered a fraudulent action. Seeking or accepting payment from both carriers is prohibited by law.

Claims filed with the wrong plan

If you file a claim with the wrong insurance carrier, Anthem will process your claim within 365 days from the date of service.

Payment of claims

After receiving a claim, Anthem:

- Analyzes the claim for covered services.
- Generates a remittance advice statement, summarizing the services rendered and the action taken.
- Sends the appropriate payment to the provider.
- Sends a DCN to the provider with the specific claims processing information.

Anthem will finalize a clean electronic or paper claim within 30 days from the date the claim is received. Anthem does not pay interest on payments made after 30 days but makes every effort to meet the 30 day metric.

Monitoring submitted claims

After claims, you can monitor and make changes to the claim by:

- Checking claim status on **Availity.com**. From the **Claims & Payments** tab select **Claims Status** to locate your claim. Calling Provider Services: **855-558-1443**.
- Confirming receipt of Plan Batch Status Reports from your vendor/clearinghouse to ensure claims have been accepted by Anthem.
- Correcting and resubmitting Plan Batch Status Reports and error reports electronically.
- Correcting errors and immediately resubmitting to prevent denials due to late filing.

Electronic Remittance Advice (835)

The 835 eliminates the need for paper remittance reconciliation.

Use Availity to register and manage ERA account changes. From b:

1. **Availity.com**, select the **My Providers** tab to access the Enrollment Center. Select **Transaction Enrollment**.

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

Contact Availity

Contact Availity Client Services with any questions at **800-Availity (282-4548)**.

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/wisconsin-provider/claims/electronic-data-interchange** for EFT registration instructions.

Use EnrollSafe (**https://enrollsafe.payeehub.org/**) to register and manage EFT account changes.

Claims overpayment recovery and refund procedure

Anthem seeks recovery of all excess claims payments from the person or entity to whom the benefit check was made payable. When an overpayment is discovered, Anthem initiates the overpayment recovery process by sending written notification. If you are notified by Anthem of an overpayment or discover that you have

been overpaid, mail the refund check, along with a copy of the notification or other supporting documentation, to the following address:
Anthem Blue Cross and Blue Shield in Wisconsin
P.O. Box 933657
Atlanta, GA 31193-3657

From our public website **https://providers.anthem.com/WI**, select the **Claims** tab. Under **Claims Submissions and Disputes** scroll down to the *Related Information* box. Find the *Recoupment Notification Form*, if you believe the overpayment notification was created in error, contact Provider Services: **855-558-1443**.

For claims re-evaluation, send your correspondence to the address indicated on the overpayment notice. If Anthem does not hear from you or receive payment within 30 days, the overpayment amount is deducted from your future claims payments.

Third-party recovery

Providers may not interfere with or place any liens upon Wisconsin's or Anthem's right, acting as Wisconsin's agent, to recovery from third-party billing.

Claim resubmissions

If you have not heard from Anthem regarding a submitted claim after 30 business days from the submission of the claim, contact us to determine the status. To determine whether you need to resubmit a claim:

- Log onto **Availity.com** and use the **Claims & Payments** tab to access **Claims Status** to locate your claim .Contact Provider Services: **855-558-1443**.

Returned claims

Claims returned for additional information

Anthem will send you a request for additional or corrected information when the claim cannot be processed due to incomplete, missing, or incorrect information. Anthem also may request additional information retroactively for a claim already paid. If you receive a request from Anthem for additional information, you must provide that information within 365 days of the date of service, or your claim may be denied.

To submit additional or corrected information, you should send the requested records or records specifically related to that claim for specific services given on the dates provided on the claim. Submit the additional information by logging ono **Availity.com** and use the **Claims & Payments** tab to select **Claims Status**. Find your claim and use the **Submit Attachment** button to upload the requested/required documentation.

Please note: Many of the claims returned for further information are returned for common billing errors. Submitting digital claims eliminates errors associated with manual processes. To file claims online, log onto **Availity.com** and select the **Claims & Payments** tab, or file claims electronically through EDI.

Common reasons for rejected and returned claims

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

Problem	Explanation	Resolution
Member's ID number is incomplete.		Use the member's ID number on the ForwardHealth card.

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

Common claim issues vs. payment appeal

The following table provides examples of claim-related issues that should not go through the payment reconsideration or appeal process.

Note: To download a copy of the **Claim Correspondence form**, go to our provider website at **https://providers.anthem.com/WI** and use the **Claims Submissions** and **Disputes** tab.

Type of issue	What do I need to do?
EOP requests for supporting documentation (sterilization/ hysterectomy/abortion consent forms, itemized bills, and invoices)	Submit the additional information by logging ono **Availity.com** and use the **Claims & Payments** tab to select **Claims Status**. Find your claim and use the **Submit Attachment** button to upload the requested/required documentation. Submit a *Claim Correspondence* form, a copy of your *EOP*, and the supporting documentation to: Anthem Blue Cross and Blue Shield Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
EOP requests for medical records	Submit the additional information by logging ono **Availity.com** and use the **Claims & Payments** tab to select **Claims Status**. Find your claim and use the **Submit Attachment** button to upload the requested/required documentation. Submit a *Claim Correspondence* form, a copy of your *EOP*, and the medical records to: Anthem Blue Cross and Blue Shield 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	Provided the claim was originally received timely, a corrected claim must be received within 365 days from the date of service. Submit a *Claim Correspondence* form and your corrected claim to: Anthem Blue Cross and Blue Shield 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'll return claims that have been altered with an explanation of the reason for return. Corrected claims can be submitted electronically via Electronic Data Interchange (EDI) (see Electronic Claims section) or using Availity.
Submission of coordination of benefits (COB)/third-party liability (TPL) information	Submit the additional information by logging ono **Availity.com** and use the **Claims & Payments** tab to select **Claims Status**. Find your claim and use the **Submit Attachment** button to upload the requested/required documentation. Submit a *Claim Correspondence* form, a copy of your *EOP*, and the COB/TPL information to: Anthem Blue Cross and Blue Shield Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599

Claims payment appeals

If a provider disagrees with the outcome of a claim decision, the provider may use the claims payment appeals process to challenge the decision. Submit a verbal or written request to the plan for reconsideration. Due to

the nature of appeals, some cannot be accepted verbally and, therefore, must be submitted in writing. The guidance below will be used in determining the appropriate submission method.

To file a verbal appeal, call Provider Services at **855-558-1443**. If the appeal must be submitted in writing, or if the provider wishes to use the written process instead of the verbal process, the appeal should be submitted to:
Anthem Blue Cross and Blue Shield
Payment Dispute Unit
P.O. Box 61599
Virginia Beach, VA 23466-1599

For participating and nonparticipating providers, the payment appeal for reconsideration, whether verbal or written, must be received by the plan within 365 days from date of service.

Using Availity

Locate the claim you want to dispute using **Claim Status** from the **Claims & Payments** menu. Select **Dispute Claim** to initiate the dispute. Go to *Request* to navigate directly to the initiated dispute in the appeals dashboard add the documentation and submit.

When submitting the appeal verbally or in writing, you must provide:

1. A listing of disputed claims.
2. A detailed explanation of the reason for the appeal.
3. Supporting statements for verbal appeals and supporting documentation for written.

The following guidance will be used in determining the appropriate reconsideration submission method.

Issue type	Submission method
Denied for timely filing	• If plan system error, then verbal • If provider needs to submit paper proof, then written
Denied for no authorization	• If authorization on file and plan system error, then verbal • If provider needs to submit paper proof, then written
Authorization issue	• If authorization is on file and clear plan system error, then verbal • If provider needs to submit paper proof or requesting retro review, then written
Denied for needing medical records*	• If records have not been received prior to call, then written • If records received and on file, then verbal * Denials issued for this reason are considered nonclean claims and should not be logged as appeals. These will be treated as inquiries/correspondence.
Provider says not paid according to their contract, at appropriate DRG or per diem rate, fee schedule, Service Case Agreement, or appropriate bed type, etc.	**Availity.com**, verbal or written
Provider indicates member doesn't have other health insurance (OHI), but claim denied for OHI	**Availity.com**, verbal or written
Claim check denial	**Availity.com**, verbal or written
Denied as duplicate	**Availity.com**, verbal or written

Issue type	Submission method
Claim denied related to provider data issue	**Availity.com**, verbal or written
Retro-eligibility issue	**Availity.com**, verbal or written
Experimental/investigational procedure denial	**Availity.com**, verbal or written
Wrong provider or member selected	**Availity.com**, verbal or written
Claims data entry error	**Availity.com**, verbal or written
Second level dispute	Second-level disputes must be submitted in writing to: Anthem Blue Cross and Blue Shield Claim Appeals P.O. Box 61599 Virginia Beach, VA 23466-1599 They will not be accepted verbally. Second-level written appeals must be received within 60 days from the date listed on the first -level resolution letter.

Claims payment appeals response timeline

Claims payment appeals are resolved by Anthem within 45 days of receipt of the verbal or written request. When we uphold or overturn a previous claim disposition, a resolution letter with the details of our decision is sent to the provider.

State appeals process

If a provider is not satisfied with the outcome or if we do not respond to an appeal within 45 days, additional steps may be taken:

- Providers may appeal to the Wisconsin DHS within 60 days of the final decision by Anthem or within 60 days from the 45-day timeline allotted to Anthem to respond.
- Providers are required to submit appeals with legible copies of all supporting documentation as outlined in the Appeals to BadgerCare Plus HMOs and Medicaid SSI HMOs (#**384**) and Appeals to ForwardHealth (#**385**) topics of the ForwardHealth Online Handbook. The decision to overturn an HMO's/PIHP's denial must be clearly supported by the documentation the provider submits. Submitting incomplete or insufficient documentation may lead to ForwardHealth upholding the HMO's/PIHP's denial.

File the appeal to the Department of Health Services through the Provider Appeals portal at https://wi-appeals.entellitrak.com/.

Covered services

Clinical submissions categories

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

- Involves precertification, predetermination or some other form of utilization review including but not limited to claims that are:
  - Pending for lack of precertification.
  - Involving medical necessity or experimental/investigative determinations.
- Requires certain modifiers.
- Includes unlisted codes.
- Is under review to determine if the service is covered; benefit determination cannot be made without reviewing medical records. This category includes but is not limited to specific benefit exclusions.

- Involves termination of pregnancy; all termination of pregnancy claims require review of medical records to determine if: 1) the pregnancy is the result of an act of rape or incest or 2) the woman suffers from a physical disorder, physical injury or physical illness, including a physical condition that endangers the woman's life and is caused by or arising from the pregnancy itself. In these cases, this condition would, as certified by a provider, place the woman in danger of death unless a termination of pregnancy is performed.
- Involves possible inappropriate or fraudulent billing.
- Is the subject of an internal or external audit, including high-dollar claims.
- Involves individuals under case management or condition care.
- Is under appeal or is otherwise the subject of a dispute, including claims being mediated, arbitrated or litigated.

Other situations in which clinical information might be requested:

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

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

Reimbursement policies

Reimbursement policies serve as a guide to assist you with accurate claims submissions and to outline the basis for reimbursement if the service is covered by the member's Anthem plan. These policies can be accessed on the provider site. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as the member's state of residence. Covered services do not guarantee reimbursement unless specific criteria are met.

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

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

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

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

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

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

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

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

Outlier reimbursement audit and review process

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.

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

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

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

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

Emergency room supplies and services charges
The Emergency Room level reimbursement includes all monitoring, equipment, supplies, and time and staff charges. Reimbursement for the use of the Emergency Room includes the use of the room and personnel employed for the examination and treatment of patients. This reimbursement does not typically include the cost of physician services.

Facility personnel charges
Charges for inpatient services for facility personnel are not separately reimbursable and the reimbursement for such is included in the room and board rate. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions (including IV or PICC line insertion at bedside), professional therapy functions, including physical, occupational, and speech, call back charges, nursing increments, therapy increments, and bedside respiratory and pulmonary function services. Charges for Outpatient Services for facility personnel are also not separately reimbursable. The reimbursement is included in the payment for the procedure or Observation charge.

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

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

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

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

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

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

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

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

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

Personal care items and services
Personal care items used for patient convenience are not separately reimbursable. Examples include but are not limited to: breast pumps, deodorant, dry bath, dry shampoo, lotion, non-medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, toothbrush and toothpaste, bedpans, chux, hot water bottles, icepacks, pillows, sitz baths, and urinals.

Provider Administered Drug Reimbursement
Reimbursement will be made for the cost of drugs prescribed by the attending physician. Additional separate charges for the administration of drugs, the cost of materials necessary for the preparation and administration of drugs, and the services rendered by registered pharmacists and other pharmacy personnel will not be reimbursed separately. All other services are included in the drug reimbursement rate. Example of pharmacy charges which are not separately reimbursable include, but are not limited to: IV mixture fees, IV diluents such as saline and sterile water, IV Piggyback (IVPB), Heparin and saline flushes to administer IV drugs, and facility staff checking the pharmacy ("Rx") cart.

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

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

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

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

Recovery room services related to iv sedation and/or local anesthesia
Separate reimbursement will not be made for a phase I or primary recovery room charged in connection with IV sedation or local anesthesia. Charges will be paid only if billed as a post procedure room or a phase II recovery (step-down) Examples of procedures include arteriograms and cardiac catheterization.

Supplies and services
Items used for the patient which are needed as a direct result of a procedure or test are considered part of the room and board or procedure charges and are not separately reimbursable.

Any supplies, items, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately reimbursable in the inpatient and outpatient environments.

Special procedure room charge

Special procedure room charges are included in the reimbursement for the procedure. If the procedure takes place outside of the OR suite, then OR time will not be reimbursed to cover OR personnel/staff being present in the room. Example: ICU, GI lab, etc.

Stand-by charges

Standby equipment and consumable items which are on standby, are not reimbursable. Standby charges for facility personnel are included in the reimbursement for the procedure and not separately reimbursable.

Stat charges

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

Supplies and equipment

Charges for medical equipment, including but not limited to, IV pumps, PCA Pumps, Oxygen, and isolation carts and supplies are not separately reimbursable.

Telemetry

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

Time calculation

Operating Room ("OR"): Time should be calculated on the time the patient enters the room until the patient leaves the room, as documented on the OR nurse’s notes.

Hospital/ Technical Anesthesia: Reimbursement of technical anesthesia time will be based on the time the patient enters the operating room (OR) until the patient leaves the room, as documented on the OR nurse’s notes. The time the anesthesiologist spends with the patient in pre-op and the recovery room will not be reimbursed as part of the hospital anesthesia time.

Recovery Room: The reimbursement of Recovery Room charges will be based on the time the patient enters the recovery room until the patient leaves the recovery room as documented on the post anesthesia care unit ("PACU") record.

Post Recovery Room: Reimbursement will be based on the time the patient leaves the Recovery Room until discharge.

Video or digital equipment used in operating room

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

Additional reimbursement guidelines for disallowed charges

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

The tables on the next pages illustrate examples of non-reimbursable items/services codes.

Examples of non-reimbursable items/services codes	
Typically billed under this/these revenue codes but not limited to the revenue codes listed below	**Description of excluded items**
0990 – 0999	Personal Care Items Courtesy/Hospitality Room Patient Convenience Items (0990) Cafeteria, Guest Tray (0991) Private Linen Service (0992) Telephone, Telegraph (0993) TV, Radio (0994) Non-patient Room Rentals (0995) Beauty Shop, Barber (0998) Other Patient Convenience Items (0999)
0220	Special Charges
0369	Preoperative Care or Holding Room Charges
0760 – 0769	Special Procedure Room Charge
0111 – 0119	Private Room* (subject to Member's Benefit)
0221	Admission Charge
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) Stand-by Charges
0220, 0949	Stat Charges
0270 – 0279, 0360	Video Equipment Used in Operating Room
0270, 0271, 0272	Supplies and Equipment Blood Pressure cuffs/Stethoscopes Thermometers, Temperature Probes, etc. 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

Examples of non-reimbursable items/services codes	
Typically billed under this/these revenue codes but not limited to the revenue codes listed below	**Description of excluded items**
	Tourniquets Syringes/Needles/Lancets/Butterflies Isolation carts/supplies Dressing Change Trays/Packs/Kits Dressings/Gauze/Sponges Kerlix/Tegaderm/OpSite/Telfa Skin cleansers/preps Cotton Balls; Band-Aids, Tape, Q-Tips Diapers/Chucks/Pads/Briefs Irrigation Solutions ID/Allergy bracelets Foley stat lock Gloves/Gowns/Drapes/Covers/Blankets Ice Packs/Heating Pads/Water Bottles Kits/Packs (Gowns, Towels and Drapes) Basins/basin sets Positioning Aides/Wedges/Pillows Suction Canisters/Tubing/Tips/Catheters/Liners Enteral/Parenteral Feeding Supplies (tubing/bags/sets, etc.) Preps/prep trays Masks (including CPAP and Nasal Cannulas/Prongs) Bonnets/Hats/Hoods Smoke Evacuator Tubing Restraints/Posey Belts OR Equipment (saws, skin staplers, staples & staple removers, sutures, scalpels, blades etc.) IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets, transducers, fluid warmers, heparin and saline flushes, etc.)
0220 – 0222, 0229, 0250	Pharmacy Administrative Fee (including mixing meds) Portable Fee (cannot charge portable fee unless equipment is brought in from another Facility) Patient transport fees
0223	Utilization Review Service Charges
0263	IV Infusion for therapy, prophylaxis (96365, 96366) IV Infusion additional for therapy IV Infusion concurrent for therapy (96368) IV Injection (96374, 96379)

Examples of non-reimbursable items/services codes	
Typically billed under this/these revenue codes but not limited to the revenue codes listed below	**Description of excluded items**
0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310	Nursing Procedures
0230	Incremental Nursing – General
0231	Nursing Charge – Nursery
0232	Nursing Charge – Obstetrics (OB)
0233	Nursing Charge – Intensive Care Unit (ICU)
0234	Nursing Charge – Cardiac Care Unit (CCU)
0235	Nursing Charge – Hospice
0239	Nursing Charge – Emergency Room (ER) or Post Anesthesia Care Unit (PACU) or Operating Room (OR)
0250 – 0259, 0636	Pharmacy (non-formulary drugs, compounding fees, nonspecific descriptions) Medication prep Nonspecific descriptions Anesthesia Gases – Billed in conjunction with Anesthesia Time Charges IV Solutions 250 cc or less, except for pediatric claims Miscellaneous Descriptions Non-FDA Approved Medications
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	Specimen collection Draw fees Venipuncture Phlebotomy Heel stick Blood storage and processing blood administration (Rev codes 0380, 0390 – 0392; 0399) Thawing/Pooling Fees
0270, 0272, 0300 – 0309	Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time, glucose, etc.)
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0410, 0460	Supplies and Equipment

Examples of non-reimbursable items/services codes	
Typically billed under this/these revenue codes but not limited to the revenue codes listed below	**Description of excluded items**
	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 Heal/Elbow Protector Burrs Cardiac Monitor EKG Electrodes Vent Circuit Suction Supplies for Vent Patient Electrocautery Grounding Pad Bovie Tips/Electrodes Anesthesia Supplies Case Carts C-Arm/Fluoroscopic Charge Wound Vacuum Pump Bovie/Electro Cautery Unit Wall Suction Retractors Single Instruments Oximeter Monitor CPM Machines Lasers Da Vinci Machine/Robot
0370 – 0379, 0410, 0460, 0480 – 0489	Anesthesia Nursing care Monitoring Intervention Pre- or Post-evaluation and education IV sedation and local anesthesia if provided by RN Intubation/Extubation CPR

Examples of non-reimbursable items/services codes	
Typically billed under this/these revenue codes but not limited to the revenue codes listed below	**Description of excluded items**
0410	Respiratory Functions: Oximetry reading by nurse or respiratory Respiratory assessment/vent management Medication Administration via Nebs, Metered dose (MDI), etc. Charges Postural Drainage Suctioning Procedure Respiratory care performed by RN
0940 – 0945	Education/Training

Chapter 9: Billing professional and ancillary claims

Chat with Payer: Log onto **Availity.com** and from Payer Spaces select Chat with Payer.
Provider Services: **855-558-1443**
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.

Overview

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

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

- Indicate the billing provider name, address (including ZIP+4) and taxonomy code, as certified with Wisconsin Medicaid in Box 33. Claims submitted with a P.O. Box entered in the address field will be rejected.
- Indicate the rendering provider's national provider identifier (NPI) number and taxonomy code, as certified with Wisconsin Medicaid in Box 24J of the CMS-1500 form, when appropriate. Missing or invalid numbers may result in nonpayment.
- Use the member's ID number from the ForwardHealth ID card OR the Anthem ID with the ZRA prefix. All providers must be certified by Wisconsin Medicaid to bill Anthem.

Preventive medicine services for new patients

Preventive medicine services for a new patient include an initial, comprehensive preventive medical evaluation. This evaluation includes an age- and gender-appropriate history, examination, counseling, risk factor interventions, and the ordering of appropriate immunizations, laboratory, and diagnostic procedures. For members under age 21, preventive medicine visits are considered HealthCheck visits. CPT codes 99381-99385 and 99391-99395 should only be used to report a comprehensive HealthCheck screen. Other preventive visits should be billed using the appropriate office visit code.

Preventive medicine services for established patients

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

Telehealth

Claims for services provided via telehealth by distant site providers must be billed with the same procedure code as would be used for a face-to-face encounter. The claim must also include POS 02 or 10 and the appropriate telehealth modifier, GQ, GT, FQ or 93 in addition to any other required benefit specific modifier(s).

Behavioral health

See the **Covered and noncovered services** chapter for more detailed information about behavioral health benefits. Anthem behavioral health has contracted with a network of hospitals and behavioral health practitioners to offer behavioral health services to our members. When rendering medically necessary behavioral health services, bill Anthem using behavioral health CPT and HCPCS codes.

Physical, speech and occupational therapies

All physical therapy, occupational therapy, and speech therapy services must be reported on the CMS-1500 claim form, regardless of whether services are rendered in a facility or clinic setting.

Emergency and related professional services

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

Emergency services do not require precertification.

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

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

Covered emergency services include:

- Hospital-based emergency department services (room and ancillary) needed to evaluate or stabilize the emergency medical or behavioral health condition.
- Professional services by emergency medicine providers.

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

Health Professional Shortage Areas

Enhanced reimbursement is provided to Medicaid-enrolled primary care providers and emergency medical providers for selected services when on or both of the following apply:

- The rendering or billing provider is located in a **HPSA (Health Professional Shortage Area)-eligible ZIP code**.
- The member has a residential address (according to enrollment records) within a HPSA-eligible ZIP code.

When billing for HPSA qualified services the appropriate modifier - AQ must be included along with the procedure code as well as the service location in Box 32. If the service location is left blank, the providers location may not be used for validation.

Immunizations covered by Vaccines for Children (VFC)

Anthem providers who administer vaccines to children through 18 years of age should enroll in the VFC program. Anthem will reimburse only the administration fee for any vaccine available through the VFC program. When billing immunizations, report the appropriate vaccine CPT code.

Maternity services

Providers may elect to bill maternity services on either a global basis or as individual services. Anthem will only reimburse the global obstetric codes when all antepartum visits, delivery and postpartum care are provided. When a global OB package is not performed, providers may bill only the individual services that were actually provided. Refer to the *Maternity Services Reimbursement Policy* for a list of services that are not separately reimbursable when a global OB CPT code is billed.

Maternity services: Newborns

Providers must bill for newborn services with the newborn's Medicaid ID number; providers may not submit claims with the mother's Medicaid ID number. Hospitals should submit a newborn report as soon as possible

after a baby is born to avoid a delay in establishing the baby's enrollment in BadgerCare Plus and ensure timely reimbursement for the provider. Providers are encouraged to help parents obtain a Medicaid ID number for the newborn.

Testing for drugs of abuse

Providers should follow the CPT coding and coverage requirements published in the ForwardHealth provider manuals when submitting claims for drug abuse testing.

Urgent care visits

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

Sterilization

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

- At least 30 days, excluding the consent and surgery dates, but not more than 180 days, must pass between the date of written consent and the surgery date.
- Prior to sterilization, the provider must complete the *Consent for Sterilization* form, which must be signed by: 1) the member, 2) the interpreter (if one was used), 3) the person who obtained consent, and 4) the physician who performed the sterilization procedure. The form is on the ForwardHealth website at: **https://www.forwardhealth.wi.gov/kw/html/SterilizationInformedConsent.html**.

Please note: Payment cannot be made to providers of associated services, including hospitals, anesthesiologists, pathologists, and radiologists, unless the consent form is completed in an accurate and timely manner. The state of Wisconsin DHS will ask for recoupment of fees from Anthem, which will subsequently be recouped from the provider.

The following are required before performing sterilization:

- Patient has voluntarily given his or her consent to be sterilized.
- Patient was at least 21 years of age on the date informed written consent is obtained.
- Patient is not mentally incompetent.
- Patient is not institutionalized.
- At least 30 days, but no more than 180 days, have elapsed between the date of consent and the sterilization.
- Consent form used is the DHS-mandated form; no other form may be substituted.
- Dates on the consent form cannot be altered.

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

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

The provider must follow these sterilization procedures for Anthem to pay the claim:

- At the time of the sterilization consult, the nurse verifies the patient is a member of Anthem. The nurse then attaches the appropriate consent form to the front of the patient's chart.

- The patient completes, signs, and dates the Consent for Sterilization section.
- If an interpreter is necessary, the interpreter signs the consent form.
- The provider completes, signs, and dates the Statement of Person Obtaining Consent section, including the name and address of the facility where the procedure will be performed.
- The scheduling nurse schedules surgery. If anything is not in order, the procedure is postponed until the issue is resolved.
- At the post-operative visit, the provider follows the instructions for use of alternative final paragraphs, signs and dates the Physician Statement on the *Sterilization Consent Form*.
- The provider forwards a copy of the signed *Sterilization Consent Form* to the facility where the procedure was performed.
- The provider files the original, signed *Sterilization Consent Form* in the member's chart.
- The provider sends a signed copy of the *Sterilization Consent Form* to Anthem, either submitted with the claim or sent separately to the claims department.

Hysterectomy

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

- The member was already sterile.
- The hysterectomy was required as the result of a life-threatening emergency situation in which the physician determined that prior acknowledgment of receipt of hysterectomy information was not possible.
- The hysterectomy was performed during a period of retroactive member eligibility, and one of the following circumstances applied:
    - The member was informed before the surgery that the procedure would make her permanently incapable of reproducing.
    - The member was already sterile.
    - The member was in a life-threatening emergency situation that required a hysterectomy.

A hysterectomy may not be performed solely for the purpose of rendering the member permanently incapable of reproduction. In addition, a hysterectomy may not be performed to correct the following medical conditions:

- Fallen uterus
- Fibroids
- Retroverted uterus

Please note: Payment cannot be made to providers of associated services, including hospitals, anesthesiologists, pathologists and radiologists, unless the Acknowledgment of *Receipt of Hysterectomy Information* form is completed accurately and in a timely manner. The state of Wisconsin DHS will ask for recoupment of fees from Anthem, which will subsequently be recouped from the provider.

Locate the ***Acknowledgment of Receipt of Hysterectomy Information*** form in the ForwardHealth provider online manual under the "Covered and Noncovered Services" section "Surgery Services."

Providers must follow these hysterectomy procedures for Anthem to pay the claim:

- At the time of the hysterectomy consultation, the nurse verifies that the patient is a member of Anthem. The nurse then attaches the Acknowledgment of Receipt of Hysterectomy Information form to the front of the patient's chart.
- The member signs the form.
- If an interpreter is necessary, the interpreter signs the form.
- The provider schedules the surgery. If everything is not in order, the procedure is postponed until the issue is resolved.
- The provider returns the signed form to medical records.

- The provider sends a signed copy of the form to Anthem.
- The provider sends a copy of the signed form to the facility where the procedure was performed.
- The provider files the original, signed form in the member's chart.

Termination of pregnancy

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

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

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

Locate the ***Abortion Certification Statement*** form in the provider online manual under the "Covered and Noncovered Services" section "Surgery Services."

Anthem reimburses for Mifeprex under the same coverage policy that it reimburses other surgical or medical abortion procedures.

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

Billing members for services not medically necessary

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

- The member requests a noncovered service or a specific service or item that, in the provider's opinion, may not be reasonable or medically necessary.
- The provider obtains a written acknowledgement, prior to rendering services, verifying that the Anthem member was notified of financial responsibility for services rendered.
- The member signs and dates the acknowledgement, indicating that the member has been notified of their responsibility to pay for the requested service prior to services being rendered.

Recommended fields for CMS-1500

All professional providers and vendors should bill Anthem using the most current version of the CMS-1500 claim form. The following guidelines will assist you in completing the CMS-1500 form. An M indicates a mandatory field.

Field	Title	Explanation
Field 1	Medicare Medicaid TRICARE CHAMPUS CHAMPVA Group Health Plan W FECA Blk Lung Other ID	If the claim is for Medicaid, put an X in the Medicaid box. If the member has both Medicaid and Medicare, put an X in both boxes. Attach a copy of the form submitted to Medicare to the claim.
Field 1a (M)	Member's ID number	Field intentionally left blank. Use the 10-digit member ID. Please note: The member ID has no prefix.
Field 2 (M)	Member's name	Enter the last name, the first name, and middle initial (if known). Do not use nicknames or full middle names.
Field 3 (M)	Member's birth date/sex	Date of birth format: MM/DD/YYYY. For example, write September 1, 1963, as 09/01/1963. Check the appropriate box for the patient's sex.
Field 4 (M)	Insured's name	"Same" is acceptable if the insured is the patient.
Field 5 (M)	Member's address/phone	Enter the member's complete address and phone number, including any unit or apartment number. Abbreviations for road, street, avenue, boulevard, place or other common endings to the street name are acceptable.
Field 6	Patient relationship to insured	The relationship to the member or subscriber.
Field 7	Insured's address	"Same" is acceptable if the insured is the patient.
Field 8	Reserved for NUCC use	None
Field 9	Other insured's name	If there is insurance coverage in addition to the member's plan coverage, enter the name of the insured.
Field 9a	Other insured's policy or group number	Enter the policy or group number of the other insured.
Field 9b	Reserved for NUCC use	None
Field 9c	Reserved for NUCC use	None
Field 9d	Insurance plan name or program name	Name of plan carrier.
Field 10	Patient's condition related to	Include any description of injury or accident and whether or not it occurred at work.
Field 10a	Related to employment?	Y or N. If insurance is related to workers' compensation, enter Y.
Field 10b	Related to auto accident/place?	Y or N; enter the state in which the accident occurred.
Field 10c	Related to other accident?	Y or N
Field 10d	Claim codes	Identify additional information about the patient's condition or the claim.
Field 11 (M)	Insured's policy, group or FECA number	Insured's policy or group number. Complete information about insured, even if the insured is the same as patient.
Field 11a	Insured's date of birth/sex	Date of birth format: MM/DD/YYYY. Sex: M or F
Field 11b	Other claim ID	This is another identifier applicable to the claim.
Field 11c	Insurance plan name or program name	Plan carrier/EP1 benefit code for paper claims.
Field 11d	Is there another health benefit plan?	Y or N; if yes, items 9A-9D must be completed.

Field	Title	Explanation
Field 12	Patient's or authorized person's signature	Signature and date; "Signature on file," indicating that the appropriate signature was obtained by the provider, is acceptable for this field.
Field 13	Member's or authorized person's signature	Signature; "Signature on file" is acceptable for this field.
Field 14	Date of current illness, injury, pregnancy (LMP)	This identifies the first date of onset of illness, the actual date of injury or the LMP for pregnancy
Field 15	Other date	This is another date related to the patient's condition or treatment. Date format: MM/DD/YYYY
Field 16	Dates patient unable to work in current occupation	This is the time span the patient is or was unable to work.
Field 17	Name of referring physician or other source	Name of physician, clinic or facility referring the patient to the provider.
Field 17a	Other ID#	The non-NPI ID number of the referring, ordering or supervising provider is the unique identifier of the professional or the provider designated taxonomy code.
Field 17b (M)	NPI	The NPI number refers to the HIPAA national provider identifier number.
Field 18	Hospitalization dates related to current services (From - To)	Date format: MM/DD/YYYY
Field 19 (M)	Additional claim information (Designated by NUCC)	This identifies additional information about the patient's condition or the claim.
Field 20	Outside lab? $ Charge	Include information here if lab services were sent to an outside lab.
Field 21 (M)	Diagnosis or nature of illness or injury	Enter the applicable ICD indicator to identify which version of ICD codes is being reported.
Field 22	Resubmission and/or original reference number	This is the code and original reference number assigned by the destination payer or receiver to indicate a previously submitted claim or encounter.
Field 23	Prior authorization number	This is the payer assigned number authorizing the service(s).
Field 24A (M)	Date(s) of service	If dates of service cross over from one year to another, submit two separate claims. Example: One claim for services in 2012 and one claim for services in 2013; itemize each date of service on the claim and avoid spanning dates.
Field 24B (M)	Place of service	Enter a two-digit code using current Wisconsin Medicaid-specified codes.
Field 24C	EMG	Enter the appropriate condition indicator for medical checkups if applicable.
Field 24D (M)	Procedure, services, or supplies	Enter the appropriate CPT codes. Indicate appropriate modifier when applicable. Do not use otherwise classified (NOC) codes unless there is no specific CPT code available. If you use an NOC code, include a narrative description.
Field 24E (M)	Diagnosis pointer	Use the most specific ICD code available.
Field 24F (M)	Dollar charges	Enter the charge for each single line item.
Field 24G	Days or units	The quantity of services for each itemized line. For anesthesia, enter the actual time of the service rendered, in minutes.

Field	Title	Explanation
Field 24H	EPSDT family plan	Indicate if the services were the result of a checkup or a family planning referral.
Field 24I (M)	ID. Qual./NPI	Enter your NPI if available. An NPI is required for electronic claims, and we strongly encourage you to use your NPI number for paper claims.
Field 24J (M)	Rendering provider ID. #	Enter the rendering provider's NPI number in the unshaded portion. Enter the rendering taxonomy code in the shaded portion.
Field 25	Federal tax ID number	Enter the nine-digit number from your W-9.
Field 26	Patient's account number	This is for the provider's use in identifying patients and allows up to nine numbers or letters (no other characters are allowed).
Field 27 (M)	Accept assignment?	All providers of Medicaid services must check YES.
Field 28 (M)	Total charge	Total charge for each single line item.
Field 29 (M)	Amount paid	Enter any payment that has been received for this claim.
Field 30	Balance due	Must equal the amount in box 28 less the amount in box 29.
Field 31 (M)	Signature of physician or supplier including degrees or credentials	This refers to the authorized or accountable person and the degree, credentials or title.
Field 32	Service facility location information	The name and address of the facility where services were rendered identifies the site where service(s) were provided.
Field 32A	NPI#	The NPI number refers to the HIPAA national provider identifier number.
Field 33 (M)	Billing provider info and phone #	The billing provider's or supplier's billing name, address, ZIP code and phone number is the billing office location and telephone number of the provider or supplier.
Field 33A (M)	Billing provider NPI	The NPI number refers to the HIPAA national provider identifier number.
Field 33B (M)	Other ID#	Enter the taxonomy code of the billing provider.

Chapter 10: Billing institutional claims

Chat with Payer: Log onto **Availity.com** and from Payer Spaces select Chat with Payer.
Provider Services: **855-558-1443**
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.

Overview

Hospital and other facility billing can require special attention because billing requirements vary according to the provider and service type. Throughout this chapter, specific billing requirements are broken down into the following service areas:

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

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

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

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

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

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

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

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

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

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

And finally, this chapter will take a look at specific coding guidelines for the CMS-1450 (UB-04) claim form for hospitals and healthcare facilities.

Basic billing guidelines

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

- Use Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT) codes or revenue codes. Valid HCPCS, CPT, or revenue codes are required for all line items billed, whether sent on paper or electronically.
- Provide medical records. Medical records for certain procedures may be requested for determination of medical necessity.
- Use modifiers in accordance with your specific billing instructions.
- Use codes for unlisted procedures. Because some provider services or procedures are not found in CPT, specific code numbers for reporting unlisted procedures have been designated. When using an unlisted procedure code, include a description of the service to help us calculate the appropriate reimbursement. We may request the member's medical records.
- Complete the appropriate billing for supplies and materials. Do not use CPT code 99070, which is for supplies and materials provided over and above those usually included with an office visit or other services. Anthem does not accept CPT code 99070. Healthcare providers must use HCPCS Level II codes, which provide a detailed description of the service.

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

Emergency room visits

Emergency room services are considered to be one continuous outpatient visit unless the member is admitted to the hospital and counted in the midnight census. If the emergency room visit results in an inpatient admission, all services provided in the emergency room must be billed in conformity with the guidelines and requirements for inpatient acute care.

The billing requirements for emergency room treatment cover all diagnostic and therapeutic services including but not limited to:

- Equipment
- Facility use (including nursing care)
- Laboratory
- Pharmaceuticals
- Radiology
- Supplies
- Other services incidental to the emergency room visit

Precertification is not required for medically necessary emergency services, but specific coding is required for emergency room billing. Use the following guidelines:

- Bill each service date as a separate line item.
- Perform a screening examination on the member, regardless of copay.
- Use CPT codes 99281-99285 for emergency room billing.
- Use ICD principal diagnosis codes as required for all services provided in an emergency room setting.
- Use revenue codes 0450-0452 and 0459 as required.

Please note: Unless clinically required, follow-up care should never occur in the emergency department. Members should be referred back to their PCP, and correct billing should follow standard, nonemergency guidelines.

Maternity services

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

- Room and board for mother (including nursing care)

- Nursery for baby (including nursing care)
- Delivery room/surgical suites
- Equipment
- Laboratory
- Pharmaceuticals
- Radiology
- Other services incidental to admission

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

Inpatient acute care

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

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

Please note: Precertification is required for all admissions except standard vaginal delivery and cesarean sections.

Inpatient clean claims review process: CERIS*

Anthem partners with CERIS, a claims review service provider. CERIS applies condition-specific medical and financial expertise to review high-dollar hospital bills for clinical appropriateness, billing errors and variances from industry billing practices. If CERIS identifies any discrepancies during its claim review, they work directly with the provider to resolve the adjustments identified.

Claims with diagnosis-related group (DRG) outlier charges will require an itemized bill to substantiate the outlier payment. If an itemized bill is not submitted with the claim, Anthem may deny the payment and request the itemized bill. Refer to returned claims information in Chapter 8.

Inpatient sub-acute care

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

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

Covered services include but are not limited to:

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

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

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

Outpatient hospital diagnostic testing, laboratory, and therapeutic services

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

Anthem adopted Wisconsin Medicaid's Enhanced Ambulatory Patient Grouping (EAPG) reimbursement methodology. Detailed information on EAPG may be found in the ForwardHealth provider manual under "Topic #15217."

Some laboratory services are not processed through the EAPG system and are reimbursed at the lower of the usual and customary charge or the maximum allowable fee. Outpatient hospitals may receive reimbursement for laboratory services resulting from specimens transferred from a source outside the hospital when the hospital laboratory is separately enrolled as an independent laboratory.

The following sections provide special billing requirements for each.

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

Ambulance services

Ambulance providers, including municipalities, should use the CMS-1500 form to bill for ambulance services. Ambulance providers are required to report pick-up and drop-off addresses on the claim form. Addresses must include street number, street name, city, state, and ZIP code.

Ambulatory surgical centers

Most outpatient surgery delivered in an ambulatory surgery center requires precertification. Ambulatory surgical centers use the CMS-1500 form.

Durable medical equipment

Durable medical equipment (DME) providers must use the CMS-1500 form. Billing for custom-made DME, prescribed to preserve bodily functions or prevent disability, requires pre-service review. Without such review, claims for DME will be denied. Prior to dispensing, please contact Anthem's Medical Management department: **855-558-1443**.

Please note: The presence of an HCPCS code does not necessarily mean that the benefit is covered or that payment will be made. Some DME codes may be by report (customized) and require additional information for pre-service review and processing.

DME billing requires a differentiation between rentals and purchased equipment as well as specific codes and modifiers. Special guidelines for DME billing include:

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

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

Durable medical equipment rentals

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

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

Durable medical equipment purchase

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

Dialysis

With the exception of a limited number of emergency dialysis treatments, hospital providers are required to be separately enrolled as a Medicaid end-stage renal disease (ESRD) provider with a specialty of "Hospital Affiliated" to receive reimbursement for renal disease-related services. Hospitals submitting claims under their hospital enrollment (not their ESRD enrollment) may receive reimbursement for providing up to three emergency dialysis treatments for a member per calendar year. These dialysis treatments are meant for emergency services only and not for a member with chronic renal failure. Precertification must be obtained for all dialysis care except where Medicare is the primary payer. Contact Anthem's Medical Management department for precertification: **855-558-1443**.

Home infusion therapy

Supplies and equipment, such as infusion pumps associated with the IV, may be separately reimbursed by Anthem. Infused solutions may be covered under the pharmacy benefit when dispensed by a pharmacy, which is a carve-out to the state. Refer to Forward Health. Refer to Provider Administered Drugs Reimbursement for infused solutions secured and administered by a physician provider.

Skilled nursing facilities

All skilled nursing facility care requires precertification. Contact Anthem's Medical Management department for precertification and bill using the CMS-1450 form. Anthem's Medical Management department phone: **855-558-1443**.

SNF providers may submit claims for Therapies (such as, OT, PT, SLP), certain DME, and certain DMS under the nursing home NPI. When billed as a professional claim. Note: Therapies require an appropriate rendering provider.

Home healthcare/personal care

All home healthcare and personal care requires precertification from Anthem's Medical Management department before delivery of service. When billing for a home-healthcare visit, use the CMS-1450 form.

Please note: When billing for supplies and equipment used in a home healthcare visit, refer to the **Durable medical equipment** section of this chapter for billing requirements. Anthem's Medical Management department phone: **855-558-1443**.

The Department of Health Services (DHS) requires Electronic Visit Verification (EVV) for Medicaid-covered personal care service. Providers can access additional information at **https://www.dhs.wisconsin.gov/evv/index.htm**

EVV Visit File required elements for claims processing

1. Provider ID
2. Member ID
3. Procedure Code
4. Date and Time visit started
5. Date and Time visit ended

Additional Anthem required elements in the EVV Visit File

1. Client Verified Times
2. Client Verified Service
3. Client Verified Tasks
4. Client Signature Available

At this time, Anthem does not recognize *live-in* workers and therefore does not recognize modifier KX. All personal care services are required to have a valid record on the EVV Visit File to qualify for reimbursement.

Providers should ensure that a valid visit occurs prior to submitting any claims to the HMO.

Hospice

When billing for hospice services, use the CMS-1450 form. Anthem's Medical Management department phone: **855-558-1443**.

Additional billing resources

The following reference books provide detailed instructions on uniform billing requirements:

- Current Procedural Terminology published by the American Medical Association (AMA)
- Healthcare Common Procedure Coding System, National Level II (current year) published by the Centers for Medicare and Medicaid Services (CMS)
- ICD (current edition) Volumes 1, 2 and 3 (current year) published by the Practice Management Information Corporation

CMS-1450 claim form

All Medicare-approved facilities should bill Anthem using the most up-to-date version of the CMS-1450 claim form. All fields must be completed using standardized code sets. These code sets are used to ensure that claims are processed in an orderly and consistent manner. HCPCS provides codes for a variety of services and consists of Level I and Level II codes:

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

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

CMS-1450 revenue codes

CMS-1450 revenue codes are required for all institutional claims.

Institutional inpatient coding

For institutional inpatient coding, use these guidelines:

- Use current applicable ICD and procedure codes in Boxes 74-74e of the CMS-1450 claim form when the claim indicates that a procedure was performed.
- Use modifier codes when appropriate; refer to the current edition of the provider's CPT manual published by the AMA.
- Refer to your Provider Agreement for diagnosis-related group (DRG) information.

Institutional outpatient coding

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

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

Please note: When using an unlisted CPT/HCPCS code, provide the name of the drug or medication and National Drug Code (NDC) in Box 43 of the CMS-1450 claim form.

Recommended fields for CMS-1450

The following guidelines will assist in completing the CMS-1450 form. An R indicates a mandatory field.

Field #	Box title	Description
1 (R)	Blank	Field intentionally left blank. Facility name, address, and phone number.
2	Blank	Field is intentionally left blank but is required when the address for payment is different than that of the billing provider information located in Box 1.
3a	PAT. CNTL #	Member's account number
3b	MED. REC #	Member's record number, which can be up to 20 characters long
4 (R)	TYPE OF BILL	Enter the type of bill (TOB) code.
5 (R)	FED. TAX NO.	Enter the provider's federal tax identification (ID) number.
6 (R)	STATEMENT COVERS PERIOD	From and through date(s) covered by the claim being submitted
8a–b (R)	PATIENT NAME	Member's name
9a–e (R)	PATIENT ADDRESS	Complete address (number, street, city, state, ZIP code and phone number)
10 (R)	BIRTHDATE	Member's date of birth in MM/DD/YY format
11 (R)	SEX	Member's gender
12 (R)	ADMISSION DATE	Member's admission date to the facility in MM/DD/YY format
13 (R)	ADMISSION HR	Member's admission hour to the facility in military time (00 to 23) format
14 (R)	ADMISSION TYPE	Type of admission
15 (R)	ADMISSION SRC	Source of admission
16 (R)	DHR	Member's discharge hour from the facility in military time (00 to 23) format
17 (R)	STAT	Patient status
18–28	CONDITION CODES	Enter condition code (81) X0 – X9
29	ACDT STATE	Accident state
31–34 (R)	OCCURRENCE CODE OCCURRENCE DATE	Occurrence code (42) and date, if applicable
35–36	OCCURRENCE SPAN (CODE, FROM and THROUGH)	Enter dates in MM/DD/YY format.

Field #	Box title	Description
38	Blank	Field is intentionally left blank but enter the responsible party name and address if applicable.
39–41	VALUE CODES (CODE and AMOUNT)	Enter value codes, if applicable.
42 (R)	REV. CD.	Revenue code (required for all institutional claims)
43 (R)	DESCRIPTION	Description of services rendered
44 (R)	HCPCS/RATE/HIPPS CODE	Enter the accommodation rate per day for inpatient services or HCPCS/CPT code for outpatient services.
45 (R)	SERV. DATE	Date of services rendered
46 (R)	SERV. UNITS	Number/units of occurrence for each line or service being billed
47 (R)	TOTAL CHARGES	Total charge for each line of service being billed
48	NONCOVERED CHARGES	Enter any noncovered charges.
50	PAYER NAME	Payer ID – Enter any third-party payers.
51 (R)	HEALTH PLAN ID	Leave this blank (assigned by the healthcare plan).
52 (R)	REL. INFO	Release of information certification indicator
53	ASG BEN.	Assignment of benefits certification indicator
54	PRIOR PAYMENTS	Prior payments
55	EST. AMOUNT DUE	Estimated amount due
56 (R)	NPI	Enter the NPI number.
57 (R)	OTHER PRIV ID	Enter the other provider ID number.
58 (R)	INSURED'S NAME	Member's name
59 (R)	P. REL	Patient's relationship to insured – Enter N/A if the member is the insured.
60 (R)	INSURED'S UNIQUE ID	Use the 10-digit member ID. Please note: The member ID has no prefix.
61	GROUP NAME	Insured group name – Enter the name of any other health plan.
62	INSURANCE GROUP NO.	Enter the policy number of any other health plan.
63	TREATMENT AUTHORIZATION CODES	Enter the authorization number or authorization information.
64	DOCUMENT CONTROL NUMBER	Enter the control number assigned to the original bill.
65	EMPLOYER NAME	Enter the name of the organization from which the insured obtained the other policy.
66 (R)	DX/PROC qualifier	Enter the diagnosis and procedure code qualifier (ICD version indicator).
67 (R)	DX	Principal diagnosis codes – Enter the ICD diagnostic codes if applicable.
67a–q (R)	DX	Other diagnostic codes – Enter the ICD diagnostic codes if applicable and indicate POA.
69	ADMIT DX	Admission diagnosis code – Enter the ICD code.
70a–c	PATIENT REASON DX	Enter the member's reason for this visit if applicable.
71	PPS CODE	Prospective payment system (PPS) code
72	ECI	External cause of injury code
74 (R)	PRINCIPAL PROCEDURE (CODE/DATE)	ICD principal procedure code and date if applicable
74a–e (R)	OTHER PROCEDURE (CODE/DATE)	Other procedure codes

Field #	Box title	Description
76 (R)	ATTENDING	Enter the attending provider’s ID number.
77 (R)	OPERATING	Enter the provider number if you use a surgical procedure on this form.
78–79	OTHER	Enter any other provider numbers if applicable.
80	REMARKS	Use this field to explain special situations.
81a–d (R)	CC	Enter taxonomy code with qualifier B3.

Chapter 11: Member transfers and disenrollment

Chat with Payer: Log onto **Availity.com** and from Payer Spaces select Chat with Payer.
Provider Services: **855-558-1443**
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.

Overview

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

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

Members also have the right to change healthcare plans, as long as they follow specific rules and timelines. If a member requests disenrollment, Anthem will provide information and assistance in the disenrollment process.

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

Anthem notifies PCPs of changes in member assignments through PCP Assignment Reports. These reports are available on Availity, our secure provider portal on our website: **https://providers.anthem.com/WI**. Select **Login** or **Register** to access the secure site. Providers also may call Provider Services: **855-558-1443**.

PCP-initiated member transfers/disenrollment

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

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

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

State agency-initiated member disenrollment

Contracted state agencies inform Anthem of membership changes by sending daily and monthly enrollment reports. These reports contain all active membership data and incremental changes to eligibility records, and Anthem disenrolls members not listed on the report. Reasons for disenrollment may include:

- Admission to a long-term care or intermediate care facility beyond the month of admission and the following month (disenrollment is 30 days for BadgerCare Plus members and 90 days for Medicaid SSI)
- Change in eligibility status
- County changes
- Death
- Incarceration
- Loss of benefits
- Member has other nongovernment or government sponsored health coverage

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

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

Member-initiated PCP reassignment

Members have the right to change their PCP at any time. When a member enrolls in Anthem, he or she may select a PCP or allow their PCP to be assigned. After that, if the member wants to make a change, he or she is instructed to call Member Services at **855-690-7800** to request an alternate PCP.

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

- The Member Services representative checks the availability of the member's choice. If the member can be assigned to the selected PCP, the Member Services representative will do so. If the PCP is not available, the representative will assist the member in finding an available PCP. If the member advises the representative that he or she is hospitalized, the PCP change will take effect upon discharge.
- Anthem notifies PCPs of member transfers through the PCP assignment report. These reports are available on Availity, our secure provider portal at **https://providers.anthem.com/WI**. Select **Login** or **Register** to access the secure site.
- The effective date of a PCP change will be the same as the date of the member request.

Members also may select a new PCP by completing the Primary Care Reassignment Request form. This form can be accessed from the **Find a Doctor** link on the provider website. The form includes fillable form fields; completed forms can be faxed to **866-840-4993**.

Member-initiated disenrollment process

When members enroll in our program, we provide instructions on disenrollment procedures. Disenrollments become effective the last day of the calendar month following administrative cut-off or are subject to the Wisconsin DHS cut-off. If a member asks a provider how to disenroll from Anthem, the provider should direct the member to call Member Services: **855-690-7800.**

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

When Member Services receives a call from a member who wants to disenroll, we attempt to find out the reason for the request and determine if we can resolve the situation. If Member Services is unable to resolve the issue, a referral is made to the member advocate in the health plan. The member advocate makes the referral to the enrollment contractor for an enrollment change if unable to resolve the situation.

Member transfers to other plans

Members may choose a different healthcare plan on an annual basis during the open enrollment period. Open enrollment is 90 days for all Medicaid members, including SSI. Within the first 90 days of enrollment, all Medicaid members may change to a different HMO if the member is not satisfied with the HMO. After the open enrollment period ends, members remain with their chosen healthcare plan for the remaining 12-month period.

Anthem-initiated member disenrollment

Anthem also may request disenrollment for a member who has moved out of the service area. When a member moves out of our service area, he or she is responsible for notifying DHS of the new permanent address. Wisconsin's DHS will disenroll the member from Anthem.

There are a number of situations where the Anthem member or member advocate can request disenrollment. They are:

- COP/CIP community-based waiver or family care
- Infants with low birth weight (under 1200 grams)
- Inmates of a public institution
- Commercial HMO
- Death
- Medicare
- Out-of-state or out-of-area move
- Loss of BadgerCare Plus eligibility or Medicaid SSI eligibility
- High-risk pregnancy

Chapter 12: Grievances and appeals

Chat with Payer: Log onto **Availity.com** and from Payer Spaces select Chat with Payer.
Provider Services: **855-558-1443**
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.
Member Services: **855-690-7800**
711 (TTY)

Overview

We encourage providers and members to seek resolution of issues through our grievances and appeals process. Verbal or written complaints and grievances are tracked and trended, resolved within established time frames, and referred to member advocates when needed. The Anthem grievances and appeals process meets all state of Wisconsin requirements and federal laws. The building blocks of this resolution process are the grievance and the appeal.

Grievance: Any expression of dissatisfaction from a provider or member to Anthem about any matter other than an adverse benefit determination.
Appeal: A review by Anthem of an adverse benefit determination.

Provider grievances and appeals are classified into the following categories:

- Grievances relating to the operation of Anthem, including:
  - Benefit interpretation
  - Claim processing
  - Reimbursement
- Provider appeals related to adverse determinations
- Provider appeals of non-medical necessity claims determinations

If a member has a grievance, we would like to hear about the issue, either by phone or in writing. Members have the right to file a grievance regarding any aspect of Anthem's services. Member grievances and appeals include but are not limited to:

- Access to healthcare services.
- Care and treatment by a provider.
- Issues having to do with how we conduct business.

Anthem does not discriminate against providers for filing a grievance or an appeal. Providers are prohibited from penalizing a member in any way for expressing a complaint or filing a grievance.

Please note: Anthem offers an expedited appeal for decisions involving urgently needed care. Standard and expedited appeals are never reviewed by a person who is subordinate to the initial decision maker.

Provider grievances and appeals

Provider grievances and appeals relating to the operation of the plan

A provider may be dissatisfied or concerned about another provider, a member or an operational issue, including claims processing and reimbursement. Provider grievances must be submitted in writing and include the following:

- Provider's name
- Date of the incident
- Description of the incident

A grievance may be filed at any time the provider became aware of the issue. Appeals may be filed up to 60 days from the receipt date of the *Notice of Action* letter advising of an adverse determination.
Anthem may request medical records or an explanation of the issues raised in the grievance via:

- Phone
- Fax (with a signed and dated letter)
- Mail (with a signed and dated letter)

The timelines for responding to the request for more information are as follows:

- Grievances or appeals: providers must comply with the request for additional information within ten days of the date on the request.
- Expedited appeals: providers must comply with the request for additional information within 24 hours of the date on the request.

Providers are notified in writing of the grievance resolution, including their right of appeal if any. Findings or decisions of peer review or quality of care issues are not disclosed.

Provider grievances and appeals: When to expect resolution

- Provider grievances: Anthem sends a written resolution letter to the provider within 30 days of the receipt of the grievance.
- Provider appeals: Anthem sends a written resolution letter to the provider within 30 days of the receipt of the appeal. The letter also provides details on further rights to appeal.

Provider grievances and appeals: Appeals related to adverse determinations

When a provider expresses dissatisfaction about an adverse determination involving a clinical issue, the case is handled automatically as an appeal or reconsideration rather than a complaint.

Adverse determination: A denial, modification or reduction of services based on eligibility, benefit coverage or medical necessity

Claims denials also are considered adverse determinations. If a provider wants to challenge a claims decision, the provider may begin a claim payment appeal.

Claim payment appeal: The process by which a provider may challenge the disposition of a claim that has already been decided.

Provider grievances and appeals: Appeals related to non-medical necessity claims determinations

Non-medical necessity determinations refer to services such as authorization requests where Utilization Management approval is sought. For example, a member is an inpatient for three days, and the provider requests an additional stay that is rejected as medically unnecessary. Non-medical necessity determinations are reviewed by the health plan's Utilization Management team, and the final determination is made by the health plan's medical director not to cover the services.

Appeals also may include retrospective medical necessity reviews. Requests for this kind of review must be submitted using the following guidelines:

- The request must include all pertinent information, be submitted within 365 days of a claim disposition and be submitted in writing to Anthem:

Anthem Blue Cross and Blue Shield
Claim Appeals/Correspondence
P.O. Box 61599
Virginia Beach, VA 23466-1599

Appeal requests are resolved within 30 days of receipt of the written request in one of the following ways:

- Anthem changes a previous claim disposition: The provider will be notified of the final disposition through a RA notice indicating the additional payment due to the provider.
- Anthem upholds a previous claim disposition: The provider will receive a resolution letter with the details of the decision.

Provider grievances and appeals: Mediation and arbitration

If the provider is not satisfied with the outcome of a review conducted through the provider appeal process, additional steps may be taken as stated in the Provider Agreement:

- Mediation
- Arbitration

If these processes have been exhausted, the provider may file a complaint with the Department of Health Services:
BadgerCare Plus and Medicaid Supplemental Security Income (SSI)
Medicaid Managed Care Unit
P.O. Box 6470
Madison, WI 53716-0470
Fax: **608-224-6318**

Members grievances and appeals

Please see the DHS guide on Member Grievances and Appeals:
https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Contracts/pdf/2020_Member_Grievances.pdf.spage

Member grievances and appeals: Filing a grievance

To help ensure that Anthem members' rights are protected, all members are entitled to a grievances and appeals process. Our goal is to resolve verbal and written grievances in a timely manner and in accordance with state and federal regulations. Members are encouraged to discuss their concerns with Anthem staff, who can resolve most verbal complaints.

The grievance and appeals team oversees and coordinates the member grievance process. The grievance and appeals team coordinates the formal grievance process, initiates investigations of grievances and ensures that appropriate follow-up occurs.

A grievance is any complaint about Anthem or any healthcare provider that is not related to a denial, limitation, reduction, or delay in your benefits. Grievances may 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 member's rights.

Grievances may be filed verbally or in writing at any time about any matter other than an adverse benefit determination by the member, provider on behalf of member or member representative.

Please call Anthem's Member Services at **855-690-7800** if you have a grievance or write to us at the following address if you have a grievance:
Anthem Blue Cross and Blue Shield
Central Appeals Processing
P.O. Box 62429
Virginia Beach, VA 23466-2429

If the concern is not resolved to the member's satisfaction, the member should bring the issue to the attention of the member advocate who can further help the member, The member advocate can be reached by calling **262-523-2424** and requesting to speak to the member advocate for Wisconsin. Or email them at **WIAnthemMedicaidMemberAdvocates@anthem.com**

The member also has the option to make a request to appear before the grievance committee. The phone number to call and make the request is **262-523-2424**. The grievance committee consists of the following individuals:

- Member advocate
- Compliance manager
- Quality director
- Medical management manager
- Provider services manager

The member must file a written grievance with as much information as possible, including:

- Who is part of the grievance
- What happened
- When the incident happened
- Where the incident happened
- Why the member was not happy with the healthcare services

The member must attach documents that will help us investigate the problem and should mail the written grievance to the Anthem Member Services department at:
Anthem Blue Cross and Blue Shield
Central Appeals Processing
P.O. Box 62429
Virginia Beach, VA 23466-2429

When the grievance committee receives a request, the committee takes the following steps:

- The member has the opportunity to meet with the grievance committee to discuss concerns about the original decision or determination.
- The grievance committee provides an initial response within ten business days.
- The grievance committee may request medical records or an explanation from the provider(s) involved in the case.
- The grievance committee notifies providers of the need for additional information either by phone, mail or fax. Written correspondence to providers includes a signed and dated letter.
- Providers are expected to respond to requests for additional information within 10 days.
- If the matter remains unresolved after 10 business days, the grievance committee makes a determination within 30 days of the initial contact.
- If the original denial centers on a treatment considered not medically necessary or experimental, additional medical information will be obtained and sent to the medical director for a second review.
- If the grievance committee is unable to resolve the grievance within the 30-day period, we will notify the member in writing and will explain the reason for the delay. This may extend the case up to an additional 14 days for members, not to exceed 45 days from receipt.

Interpreter services and translation of materials into non-English languages and alternative formats are available to support members with the grievance and appeals process at no cost.

Member grievances and appeals: Resolution

Anthem investigates the member’s grievance to develop a resolution. After we make a determination, we send a resolution letter to the member outlining the following:

- Anthem staff present during the meeting

- Documents reviewed to make the determination
- Appeal options (if applicable)

Member grievances and appeals: Appeals

If a member would like to file an appeal regarding how we solved their problem, the member, member's authorized representative or provider acting on behalf of the member must notify us within 60 calendar days of the date the member receives the notice of action letter. The request can be filed verbally or in writing. Appeals are divided into the following categories: standard appeal and expedited appeal.

Standard appeal: The appropriate process when a member or his or her representative requests that Anthem reconsider the denial of a service or payment for services, in whole or in part.

Expedited appeals: An appeal when the amount of time necessary to complete a standard appeal process could jeopardize the member's life, health, or the ability to maintain or regain maximum function.

Members have the right to appeal Anthem's denial of services or payment for services, in whole or in part. A denial of this type is called an action. A member or his or her representative may submit a verbal or written appeal regarding an action within 60 calendar days from the date the member receives the denial letter. With the exception of expedited appeals, all appeals submitted by a member representative or provider on behalf of member must be consented to by the member or his or her authorized representative.

Member grievances and appeals: Response to standard appeals

After Anthem receives a verbal or written appeal request, the grievances and appeals department takes into consideration and investigates the case. The member, his or her representative, and the provider are given the opportunity to submit written comments and documentation relevant to the appeal. Anthem may request medical records or a provider explanation of the issues raised in the appeal by:

- Phone
- Fax (with a signed and dated letter)
- Mail (with a signed and dated letter)

Providers are expected to comply with the request for additional information within ten days.

When the appeal is the result of a medical necessity determination, a physician clinical reviewer of the same or similar specialty who was not involved in the initial decision reviews the case. The physician clinical reviewer contacts the provider if needed to discuss possible alternatives. If specialty care is in dispute, the appeal panel will include a specialist who works in the same field of care.

The steps of the appeals process are as follows:

- No later than seven business days before the appeal panel is to meet, Anthem will share with the member or his or her representative the documentation that will be presented to the appeal panel.
- Anthem will provide the names of providers consulted during the investigation and the name and affiliation of each Anthem representative on the appeal panel.
- The member or his or her representative will be notified of their right to appear in person before the appeal panel.
- The member or his or her representative may present alternative expert testimony or request the presence of and question any person responsible for making the disputed decision.

Member grievances and appeals: Resolution of standard appeals

Standard appeals are resolved within 30 calendar days of receipt of the initial written or verbal request. Members are notified in writing of the appeal resolution, including their right to further appeal if any.

Member grievances and appeals: Appeal time frame extensions

The resolution time frame for an appeal not related to an ongoing hospitalization or emergency may be extended up to fourteen calendar days if:

- The member or his or her representative requests an extension.
- Anthem shows that there is a need for additional information, and the delay is in the member's interest.

Member grievances and appeals: Expedited appeals

If the amount of time necessary to participate in a standard appeal process could jeopardize the member's life, health, or ability to attain, maintain or regain maximum function, the member may request an expedited appeal. Anthem will inform the member of the time frame available for providing information and that the duration for submitting an expedited appeal is limited.

Member grievances and appeals: Timeline for expedited appeals

Members have the right to request an expedited appeal within 60 calendar days of receipt of the denial letter. Expedited appeals are acknowledged by phone and, if possible, immediately. Anthem will follow up with a written acknowledgement.

If Anthem denies a request for an expedited appeal, we must:

- Transfer the appeal to the time frame for standard resolution.
- Make a reasonable effort to give the member prompt verbal notice of the denial and follow up within two days with written notice.

Member grievances and appeals: Response to expedited appeals

Anthem may request medical records or a provider explanation of the issues raised in an expedited appeal by:

- Phone.
- Fax (with a signed and dated letter).
- Mail (with a signed and dated letter).

Providers are expected to comply with the request for additional information within 24 hours.

Member grievances and appeals: Resolution of expedited appeals

Anthem resolves expedited appeals as quickly as possible and within 72 hours. The member is notified by phone whenever possible and in writing within five days of the expedited appeal decision.

Member grievances and appeals: Other options for filing grievances

After exhausting Anthem's grievances and appeals process, if a member is still dissatisfied with the decision, the member has the right to file an appeal with the Wisconsin Division of Hearings and Appeals (DHA) by requesting a state fair hearing.

The member can file a grievance with the Wisconsin BadgerCare Plus managed care ombudsman:
Wisconsin BadgerCare Plus Managed Care Ombudsman
P.O. Box 6470
Madison, WI 53716-0470
800-760-0001

Member grievances and appeals: State fair hearing

Members may request a state fair hearing after they have exhausted all of Anthem's internal appeal processes. The request must be filed within 90 calendar days from the date the member receives the resolution letter. The request must be submitted in writing to the state of Wisconsin:
Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

The process is as follows:

- The state sends a notice of the hearing request to Anthem.
- Upon receipt of the request, we forward all documents related to the request to the state.
- The state of Wisconsin schedules a hearing within the county where the member lives.
- The state notifies all parties of the date, time, and place of the hearing. Representatives from our administrative, medical, and legal departments may attend the hearing to present testimony and arguments. Our representatives may cross-examine witnesses and offer rebutting evidence.
- An administrative law judge renders a decision in the hearing within 90 calendar days of the date the hearing request was made.
- If the judge overturns Anthem's position, we must adhere to the judge's decision and ensure the decision is carried out.

Please note: If the member needs special arrangements to attend the hearing due to a disability or needs English language translation services please call the Wisconsin DHA:

- Phone: 608-266-3096
- TTY: 608-264-9853

Please note: If the member needs help in filing a grievance or wants to know more about their rights, the member may call:

- BadgerCare Plus/Medicaid SSI ombudsman: **800-760-0001**
- Health maintenance organization (HMO) enrollment specialist: **800-291-2002**

Member grievances and appeals: Confidentiality

All grievances and appeals are handled in a confidential manner. We do not discriminate against a member for filing a grievance or requesting a state fair hearing. We notify members of our grievances and appeals process in the member handbook. Members may request a translated version in languages other than English.

Member grievances and appeals: Discrimination

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

Member grievances and appeals: Continuation of benefits during appeal

Members must file a request for a hearing with the Wisconsin DHA within ten days of receiving a notice of action letter from Anthem regarding a decision to reduce, limit, terminate or suspend benefits. After the DHA notifies Anthem that an appeal is underway, we will notify the member that they are eligible to continue receiving care. We also will notify the member that they may be liable for the costs of that care if the DHA upholds our decision. If the member requests that we continue coverage, the following conditions apply:

- If the DHA reverses Anthem's decision, we are responsible for covering services provided during the administrative hearing process.

- If the DHA upholds Anthem's decision, we may pursue reimbursement for all services provided to the member to the extent that services were rendered solely because of this requirement.

Anthem will continue to provide benefits until one of the following occurs:

- The member withdraws the appeal.
- The state fair hearing's decision is adverse to the member.
- The authorization expires, or the authorization service is met.

Member grievances and appeals: Additional options for filing a grievance

An additional avenue is open to members who want to file a grievance. Members may contact the Wisconsin Office of the Commissioner of Insurance (OCI), the state agency that enforces Wisconsin's insurance laws, and request a complaint form from the OCI:

- Phone outside the Madison area: **800-236-8517**
- Phone within the Madison area: **608-266-0103**
- Members may write to:

Office of the Commissioner of Insurance
Attn: Information and Complaints Section
P.O. Box 7873
Madison, WI 53707-7873

Chapter 13: Credentialing and recredentialing

Chat with Payer: Log onto **Availity.com** and from Payer Spaces select Chat with Payer.
Provider Services: **855-558-1443**
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.

Credentialing scope

Anthem credentials the following healthcare practitioners:

- Medical doctors
- Doctors of osteopathic medicine
- Doctors of podiatry
- Chiropractors
- Optometrists providing health services covered under the health benefits plan
- Doctors of dentistry providing health services covered under the health benefits plan including oral maxillofacial surgeons
- Psychologists who have doctoral or master's level training
- Clinical social workers who have master's level training
- Psychiatric nurse practitioners who have master's level training
- Other behavioral healthcare specialists who are licensed or certified by the state to practice independently
- Telemedicine practitioners who provide treatment services under the health benefits plan
- Medical therapists (for example, physical therapists, speech therapists and occupational therapists)
- Genetic counselors
- Audiologists who are licensed by the state to practice independently
- Acupuncturists (nonmedical doctors or doctors of osteopathic medicine) who are licensed, certified or registered by the state to practice independently
- Nurse practitioners who are licensed by the state to practice independently
- Certified nurse midwives who are licensed by the state to practice independently
- Physician assistants (as required locally)

The following behavioral health practitioners are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Certified behavioral analysts
- Certified addiction counselors
- Substance abuse practitioners

Anthem credentials the following health delivery organizations (HDOs):

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Nursing homes
- Freestanding surgical centers
- Behavioral health facilities providing mental health and/or substance abuse treatment in an inpatient, residential or ambulatory setting:
    - 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 abuse

    - Methadone maintenance clinics
    - Outpatient mental health clinics
    - Outpatient substance abuse clinics
    - Partial hospitalization — mental health and/or substance abuse
    - Residential treatment centers (RTC) — psychiatric and/or substance abuse
- Birthing centers
- Home Infusion Therapy when not associated with another currently credentialed HDO

The following health delivery organizations are not subject to professional conduct and competence review under Anthem'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)
- Portable X-ray suppliers (CMS Certification)
- Home Infusion Therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)
- Federally Qualified Health Centers (FQHC) (CMS Certification)
- Rural Health Clinics (CMS Certification)

Credentials committee

The decision to accept, retain, deny, or terminate a practitioner's participation in a network or plan program is conducted by a peer review body, known as Anthem's credentials committee (CC).

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

The CC will access various specialists for consultation as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member: 1) believes there is a conflict of interest, such as direct economic competition with the practitioner, or 2) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant's participation or terminate a practitioner from participation in one or more networks or plan programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are network practitioners.

During the credentialing process, all information that is obtained is highly confidential. All CC meeting minutes and practitioner files are stored in locked cabinets and can only be seen by appropriate credentialing

staff, medical directors and CC members. Documents in these files may not be reproduced or distributed, except for confidential peer review and credentialing purposes. Peer review protected information will not be shared externally.

Practitioners and HDOs are notified they have the right to review information submitted to support their credentialing applications. This right includes access to information obtained from any outside sources with the exception of references, recommendations or other peer review protected information. Providers are given written notification of these rights in communications from Anthem, which initiates the credentialing process. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, the credentialing staff will contact the practitioner or HDO within 30 calendar days of the identification of the issue. This communication will specifically notify the practitioner or HDO of the right to correct erroneous information or provide additional details regarding the issue in question. This notification will also include the specific process for submission of this additional information, including where it should be sent. Depending on the nature of the issue in question, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue(s) in question, including copies of the correspondence or a detailed record of phone calls, will be clearly documented in the practitioner's credentials file. The practitioner or HDO will be given no less than 14 calendar days to provide additional information. Upon request, the 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 Anthem, including the letter initiating the credentialing process, the provider website or provider manual. When such requests are received, providers will be notified whether the credentialing 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.

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

Anthem will not discriminate against any applicant for participation in its networks or plan programs on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran or marital status, or any unlawful basis not specifically mentioned herein. Additionally, Anthem will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities that are provided to the covered individuals to meet their needs and preferences, this information is not required in the credentialing and recredentialing process. Determinations as to which practitioners/HDOs require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence as outlined in Anthem Credentialing Program Standards. CC decisions are based on issues of professional conduct and competence, as reported and verified through the credentialing process.

Initial credentialing

Each practitioner or HDO must complete a standard application form when applying for initial participation in one or more of Anthem's networks or plan programs. This application may be a state-mandated form or a standard form created by or deemed acceptable by Anthem. For practitioners, the Council for Affordable Quality Healthcare (CAQH), a universal credentialing data source, is utilized. CAQH built the first national provider credentialing database system, which is designed to eliminate the duplicate collection and updating of provider information for health plans, hospitals and practitioners. To learn more about CAQH, visit their website at **www.CAQH.org**.

Anthem will verify those elements related to an applicants' legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All

verifications must be current and verified within the 180-calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

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

A. Practitioners

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

B. HDOs

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

Recredentialing

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

During the recredentialing process, Anthem will review verification of the credentialing data, as described in the tables under Initial Credentialing, unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

All applicable practitioners and HDOs in the network within the scope of the Anthem credentialing program are required to be recredentialed every three years, unless otherwise required by contract or state regulations.

Health delivery organizations

New HDO applicants will submit a standardized application to Anthem for review. If the candidate meets Anthem screening criteria, the credentialing process will commence. HDOs are subject to credentialing and recredentialing programs to assess whether they meet appropriate standards of professional conduct and competence within the scope of the credentialing program. As described in detail in our credentialing program standards, all network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body in addition to the licensure and other eligibility criteria. In the absence of such accreditation, Anthem may evaluate: 1) the most recent site survey by Medicare, 2) the appropriate state oversight agency or 3) a site survey performed by a designated independent external entity within the past 36 months for that HDO.

Recredentialing of HDOs occurs every three years, unless otherwise required by regulatory or accrediting bodies. Each HDO applying for continuing participation in networks or plan programs must submit all required supporting documentation.

On request, HDOs will be provided with the status of their credentialing application. Anthem may request, and will accept, additional information from the HDO to correct incomplete, inaccurate or conflicting credentialing information. The CC will review this information and the rationale behind it as presented by the HDO, and determine if a material omission has occurred or if other credentialing criteria are met.

Ongoing sanction monitoring

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

- Office of the Inspector General (OIG)
- Federal Medicare/Medicaid reports
- Office of Personnel Management (OPM)
- State licensing boards/agencies
- Covered individual/customer services departments
- Clinical quality management department (including data regarding complaints of both a clinical and nonclinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
- Other internal Anthem departments
- Any other verified information received from appropriate sources

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

Appeals process

Anthem has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one (1) or more of Anthem's Networks or Plan Programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Anthem may wish to terminate practitioners or HDOs. Anthem also seeks to treat Network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating/denying participation in Anthem's Networks for professional conduct and competence reasons, or which would otherwise result in a report to the National Practitioner Data Bank ("NPDB"). Additionally, Anthem will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is Anthem's intent to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one (1) or more of Anthem's Networks or Plan Programs and those denials of request for initial participation which are reported to the NPDB that were based on professional conduct and competence considerations. Immediate terminations may be imposed due to the practitioner's or HDO's license suspension, probation or revocation, if a practitioner or HDO has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, has a criminal conviction, or Anthem's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to Members. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for informal Review/Reconsideration or Formal Appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for Informal Review/Reconsideration or Formal Appeal.

Reporting requirements

When Anthem takes a professional review action with respect to a practitioner's or HDO's participation in one (1) or more of its Networks or Plan Programs, Anthem may have an obligation to report such to the NPDB, state licensing board and legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

Anthem credentialing program standards

Eligibility criteria – Healthcare practitioners

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

I. Must not be currently federally sanctioned, debarred or excluded from participation in Medicare, Medicaid or FEHBP
II. Possess a current, valid, unencumbered, unrestricted and nonprobationary license in the state(s) where he/she provides services to covered individuals
III. Possess a current, valid and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if applicable to his or her specialty (Note: the DEA/CDS registration must be valid in the state[s] in which the practitioner will be treating covered individuals. Practitioners who see covered individuals in more than one state must have a DEA/CDS registration for each state.)

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

I. For MDs, DOs, DPMs, and oral and maxillofacial surgeons, the applicant must have a current, in-force board certification as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Podiatric Surgery (ABPS), American Board of Podiatric Medicine (ABPM), or American Board of Oral and Maxillofacial Surgery (ABOMS) in the clinical discipline for which they are applying:

a. Individuals will be granted five years or 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.
b. Individuals with board certification from the ABPM 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.
c. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training, and certification requirement:
    i. Previous board certification (as defined by ABMS, AOA, RCPSC or CFPC) in the clinical specialty or subspecialty for which they are applying which has now expired AND a minimum of ten consecutive years of clinical practice
    ii. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty
    iii. Specialized practice expertise, as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty AND a faculty appointment of assistant professor or higher at an academic medical center and teaching facility in Anthem's network AND the applicant's professional activities are spent at that institution at least 50% of the time

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

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

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

Criteria for selecting practitioners — New applicants (credentialing):

I. Submission of a complete application and required attachments that must not contain intentional misrepresentations
II. Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote
III. Primary source verifications within acceptable time frames of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies
IV. No evidence of potential material omission(s) on application
V. Current, valid and unrestricted license to practice in each state in which the practitioner would provide care to covered individuals
VI. No current license action
VII. No history of licensing board action in any state

VIII. No current federal sanction and no history of federal sanctions (per System for Award Management [SAM], OIG and OPM report, or NPDB report)

IX. Possess a current, valid and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his or her specialty in which he or she will treat covered individuals. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating covered individuals. Practitioners who treat covered individuals in more than one state must have a valid DEA/CDS registration for each applicable state. Initial applicants who have NO DEA/CDS registration will be viewed as not meeting criteria, and the credentialing process will not proceed. However, if the applicant can provide evidence that he or she has applied for a DEA/CDS registration, the credentialing process may proceed if <u>all</u> of the following are met:

a. It can be verified that this application is pending.
b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained.
c. The applicant agrees to notify Anthem upon receipt of the required DEA/CDS registration.
d. Anthem will verify the appropriate DEA/CDS registration via standard sources.
e. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90-calendar day time frame will result in termination from the network. Initial applicants who possess a DEA/CDS registration in a state other than the state in which they will be treating covered individuals will be notified of the need to obtain the additional DEA/CDS registration. If the applicant has applied for additional DEA/CDS registration, the credentialing process may proceed if *all* the following criteria are met:
    i. It can be verified that this application is pending.
    ii. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained.
    iii. The applicant agrees to notify Anthem upon receipt of the required DEA/CDS registration.
    iv. Anthem will verify the appropriate DEA/CDS registration via standard sources.
    v. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90-calendar day time frame will result in termination from the network.
    vi. The applicant must not be currently federally sanctioned, debarred or excluded from participation in Medicare, Medicaid or FEHBP.

X. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions

XI. No history or current use of illegal drugs or history of or current alcoholism

XII. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field

XIII. No gap in work history greater than six months in the past five years, with the exception of those gaps related to parental leave or immigration, where 12-month gaps will be acceptable. Other gaps in work history of six to 24 months will be reviewed by the chair of the CC and may be presented to the CC if the gap raises concerns of future substandard professional conduct and competence. In the absence of this concern, the chair of the CC may approve work history gaps of up to two years.

XIV. No history of criminal/felony convictions or a plea of no contest

XV. A minimum of the past ten years of malpractice case history is reviewed.

XVI. Meets credentialing standards for education/training for the specialty(ies), as designated on the application, the practitioner wants to be listed under in Anthem's network directory. This includes board certification requirements or alternative criteria for MDs and DOs and board-certification criteria for DPMs and oral and maxillofacial surgeons.

XVII. No involuntary terminations from an HMO or PPO

XVIII. No *yes* answers to attestation/disclosure questions on the application form, with the exception of the following:

a. Investment or business interest in ancillary services, equipment or supplies
b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization
c. Voluntary surrender of state license related to relocation or nonuse of said license

d. A NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria
e. Nonrenewal of malpractice coverage or a change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business)
f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year, post-residency training window
g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion
h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction

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

Practitioners who meet all participation criteria for initial or continued participation and whose credentials have been satisfactorily verified by the Credentialing department may be approved by the chair of the CC after review of the applicable credentialing or recredentialing information. This information may be in summary form and must include, at a minimum, the practitioner's name, and specialty.

Criteria for selecting practitioners – Currently participating applicants (recredentialing)

I. Submission of complete recredentialing application and required attachments, which must not contain intentional misrepresentations
II. Recredentialing application signed date within 180 calendar days of the date of submission to the CC for a vote
III. Primary source verifications within acceptable time frames of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies
IV. No evidence of potential material omission(s) on recredentialing application
V. Currently participating providers must not be currently federally sanctioned, debarred or excluded from participation in Medicare, Medicaid or FEHBP. If federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs to a participating practitioner, he or she will become immediately ineligible for participation in the applicable government programs or provider network(s) as well as Anthem's other credentialed provider network(s) at the time of identification. Special consideration regarding the practitioner's continued participation in Anthem's other credentialed practitioner network(s) may be requested by the vice president (VP) responsible for that network(s) if, in the opinion of the requesting VP: 1) the federal sanction, debarment or exclusion is not reflective of significant issues of professional conduct and 2) competence and participation of the practitioner is important for network adequacy. The request, with supporting information, will be brought to Anthem's geographic credentials committee for consideration and final determination. There will be no practitioner appeal rights related to the special consideration regarding the practitioner's continued participation in Anthem's other credentialed provider network(s) if such participation would be permitted under applicable state regulation, rule or contract requirements.
VI. Current, valid and unrestricted license to practice in each state in which the practitioner provides care to covered individuals
VII. No current license probation*
VIII. Unencumbered license*
IX. No new history of licensing board reprimand since prior credentialing review
X. No current federal sanction and no new (that is, since the previous credentialing review) history of federal sanctions (per SAM, OIG and OPM reports, or NPDB report)*
XI. Current DEA/CDS registration and/or State Controlled Substance certification without new (that is, since the previous credentialing review) history of or current restrictions
XII. No current hospital membership or privilege restrictions and no new (that is, since the previous credentialing review) history of hospital membership or privilege restrictions; OR for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting, there

exists a defined referral relationship with a network practitioner of similar specialty at a network HDO who provides inpatient care to covered individuals needing hospitalization.

XIII. No new (that is, since the previous credentialing review) history of or current use of illegal drugs or alcoholism

XIV. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field

XV. No new (that is, since the previous credentialing review) history of criminal/felony convictions, including a plea of no contest

XVI. Malpractice case history reviewed since the last CC review (Note: If no new cases are identified since the last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of the last five years of malpractice history is evaluated and the criteria consistent with initial credentialing are used.)

XVII. No new (that is, since the previous credentialing review) involuntary terminations from an HMO or PPO

XVIII. No new (that is, since the previous credentialing review) *yes* answers on attestation/disclosure questions, with exceptions of the following:

a. Investment or business interest in ancillary services, equipment, or supplies
b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization
c. Voluntary surrender of state license related to relocation or nonuse of said license
d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria
e. Nonrenewal of malpractice coverage or change in the malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business)
f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year, post-residency training window
g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion
h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction

XIX. No QI data or other performance data, including complaints above the set threshold

XX. Recredentialed at least every three years to assess the practitioner's continued compliance with Anthem standards

The CC will individually review any credentialed network practitioners and HDOs that do not meet one or more of the criteria for recredentialing.

* It is expected that these findings will be discovered for currently credentialed network practitioners and HDOs through ongoing sanction monitoring. Network practitioners and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Additional participation criteria and exceptions for behavioral health practitioners (nonphysician) credentialing:

I. Licensed clinical social worker (LCSW) or other master-level social work license type:
    a. Master or doctoral degree in social work, with an emphasis in clinical social work, from a program accredited by the Council on Social Work Education (CSWE) or the Canadian Association on Social Work Education (CASWE):
        i. Program must have been accredited within three years of the time the practitioner graduated.
        ii. Full accreditation is required; candidacy programs will not be considered.
        iii. If master's level degree does not meet criteria and practitioner obtained PhD training as a clinical psychologist but is not licensed as such, the practitioner can be reviewed. To meet the criteria, the doctoral program must be accredited by the American

Psychological Association (APA) or be regionally accredited by the Council for Higher Education Accreditation (CHEA). In addition, a doctor of social work from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.

II. Licensed professional counselor (LPC) and marriage and family therapist (MFT) or other master-level license type:
    a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling, or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above:
        i. Master or doctoral degrees in divinity do not meet criteria as a related field of study.
        ii. The graduate school must be accredited by one of the regional institutional accrediting bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, Council for Accreditation of Counseling and Related Educational Programs (CACREP), or Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) listings. The institution must have been accredited within three years of the time the practitioner graduated.
        iii. Practitioners with PhD training as a clinical psychologist can be reviewed. To meet the criteria, this doctoral program must either be accredited by the APA or be regionally accredited by the CHEA. A practitioner with a doctoral degree in one of the fields of study noted will be viewed as acceptable if the institution granting the degree has regional accreditation from the CHEA and licensure to practice independently.

III. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
    a. Master's degree in nursing, with specialization in adult or child/adolescent psychiatric and mental health nursing:
        i. The graduate school must be accredited from an institution accredited by one of the regional institutional accrediting bodies within three years of the time of the practitioner's graduation.
    b. Registered nurse license and any additional licensure as an advanced practice nurse/certified nurse specialist/adult psychiatric nursing or other license or certification as dictated by the appropriate state(s) board of registered nursing (if applicable)
    c. Certification by the American Nurses Association (ANA) in psychiatric nursing (Note: 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, and unrestricted DEA/CDS registration where applicable with appropriate supervision/consultation by a network practitioner as applicable by the state licensing board (Note: For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating covered individuals.)

IV. Clinical psychologist:
    a. Valid state clinical psychologist license
    b. Doctoral degree in clinical or counseling, psychology, or other applicable field of study from an institution accredited by the APA within three years of the time of the practitioner's graduation
    c. Education/training considered as eligible for an exception is a practitioner whose doctoral degree is not from an APA-accredited institution, but who is listed in the National Register of Health Service Providers in Psychology or is a diplomat of the American Board of Professional Psychology.
    d. Master's level therapists in good standing in the network who upgrade their license to clinical psychologist as a result of further training will be allowed to continue in the network and will not be subject to the above education criteria.

V. Clinical neuropsychologist:

a. Must meet all the criteria for a clinical psychologist listed in section 4 above and be board certified by either the American Board of Professional Neuropsychology (ABPN) or the American Board of Clinical Neuropsychology (ABCN)
b. A practitioner credentialed by the National Register of Health Service Providers in Psychology with an area of expertise in neuropsychology may be considered.
c. Clinical neuropsychologists who are not board certified or listed in the national register will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by *one* or more of the following:
    i. Transcript of applicable predoctoral training
    ii. Documentation of applicable formal one-year, post-doctoral training (participation in CEU training alone would not be considered adequate)
    iii. Letters from supervisors in clinical neuropsychology (including number of hours per week)
    iv. Minimum of five years of experience practicing neuropsychology at least 10 hours per week

VI. Licensed psychoanalyst:
    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 the credentialing policy (for example, a psychiatrist, clinical psychologist, or licensed clinical social worker).
    c. Practitioner must possess a valid psychoanalysis state license.
    d. Practitioner shall possess a master's or higher degree from a program accredited by one of the regional institutional accrediting bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, CACREP or the COAMFTE listings. The institution must have been accredited within three years of the time the practitioner graduates:
        i. Completion of a program in psychoanalysis registered by the licensing state as licensure qualifying; or accredited by the American Board for Accreditation in Psychoanalysis (ABAP) or another acceptable accrediting agency; or determined by the licensing state to be the substantial equivalent of such a registered or accredited program
        ii. A program located outside the United States and its territories may be used to satisfy the psychoanalytic study requirement if the licensing state determines the following: it prepares individuals for the professional practice of psychoanalysis; it is recognized by the appropriate civil authorities of that jurisdiction; it can be appropriately verified; and it is determined by the licensing state to be the substantial equivalent of an acceptable registered licensure qualifying or accredited program.
    e. Meet minimum supervised experience requirement for licensure as a psychoanalyst, as determined by the licensing state
    f. Meet examination requirements for licensure, as determined by the licensing state

Additional participation criteria and exceptions for nurse practitioners, certified nurse midwives and physicians assistants (nonphysician) credentialing:

I. 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 either via verification of the licensure status from the state licensing agency, provided that that agency verifies the education, or from the certification board, if that board provides documentation that it performs primary verification of the professional education and training. If the licensing agency or certification board does not

verify highest level of education, the education will be primary-source verified, in accordance with policy.

c. The license status must be that of NP, as verified via the primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered and 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 (allowing the prescription of scheduled drugs), their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal company 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 <u>one</u> of the following:

II. Certification program of the American Nurse Credentialing Center **https://www.nursingworld.org/ancc**, a subsidiary of the American Nursing Association;

III. American Academy of Nurse Practitioners – Certification Program **https://www.aanpcert.org**;

IV. National Certification Corporation **http://www.nccwebsite.org**;

V. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner) **https://www.pncb.org**;

VI. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY **http://oncc.org**; or

VII. This certification must be active and primary-source verified. If the state licensing board primary source verifies this certification as a requirement for licensure, additional verification by the company is not required. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.

VIII. American Association of Critical Care Nurses **https://www.aacn.org/certification/verify-certification** ACNPC – Adult Care Nurse Practitioner; ACNPC-AG – Adult Gerontology Acute Care.

f. If the NP has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO or HFAP-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.

Additional notes on process, requirements, and verification:

g. The NP applicant will undergo the standard credentialing processes outlined in credentialing policies 4-17. NPs are subject to all the requirements outlined in these credentialing policies, including but not limited to 1) the requirement for committee review of Level II files for failure to meet predetermined criteria, 2) recredentialing every three years, and 3) continuous sanction and performance monitoring upon participation in the network.

h. Upon completion of the credentialing process, the NP may be listed in the company provider directories. As with all providers, this listing will accurately reflect their specific licensure designation, and these providers will be subject to the audit process. NPs will be clearly identified:

i. On the credentialing file.

ii. At presentation to the credentialing committee.

iii. On notification to Network Services and to the provider database.

IX. 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, which 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 the state licensing agency performs

verification of the education, or from the certification board, if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary-source verified, in accordance with policy.

c. The license status must be that of CNM as verified via the primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered and 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 (allowing the prescription of scheduled drugs), their DEA and/or state certificate of prescriptive authority information will be requested and primary-source verified via normal company 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:
    i. The National Certification Corporation for OB/GYN and Neonatal Nursing.
    ii. The American Midwifery Certification Board, previously known as the American College of Nurse Midwifes.

This certification must be active and primary-source verified. If the state licensing board primary source verifies one of these certifications as a requirement for licensure, additional verification by the company is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic credentialing committee:

f. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO or HFAP-accredited hospital or a network hospital previously approved by the committee. In the absence of such privileges, the CNM 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. Additional notes on process, requirements and verifications:
    i. The CNM applicant will undergo the standard credentialing process outlined in Credentialing Policies 4-16. CNMs are subject to all the requirements of these credentialing policies including (but not limited to): the requirement for committee review for Level II applicants, recredentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
    ii. Upon completion of the credentialing process, the CNM may be listed in the company provider directories. As with all providers, this listing will accurately reflect their specific licensure designation, and these providers will be subject to the audit process.
    iii. CNMs will be clearly identified:
        1. On the credentialing file.
        2. At presentation to the credentialing committee.
        3. On notification to Network Services and to the provider database.

III. Process, requirements, and verifications — physician's assistants (PA):

a. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners, with the exception of differing information regarding education/training and board certification.
b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency, provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary-source verified, in accordance with policy.

c. The license status must be that of PA, as verified via the primary source from the appropriate state licensing agency. Additionally, this license must be active; unencumbered; unrestricted; and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid, will be notified of this, and the applicant will be administratively denied.
d. If the PA has prescriptive authority (allowing the prescription of scheduled drugs), their DEA and/or state certificate of prescriptive authority information will be requested and primary-source verified via normal company procedures. If there are in-force adverse actions against the DEA, the applicant will be notified, and the applicant will be administratively denied.
e. All PA applicants will be certified by the National Commission on Certification of Physician's Assistants. This certification must be active and primary-source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by the company 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 geographic credentialing policy 8 and submitted for individual review by the credentialing committee.
f. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP-accredited hospital or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
g. Additional notes about process, requirements and verifications:
    i. The PA applicant will undergo the standard credentialing process outlined in credentialing policies 4-16. PAs are subject to all the requirements described in these credentialing policies, including but not limited to 1) committee review of Level II files failing to meet predetermined criteria, 2) recredentialing every three years, and 3) continuous sanction and performance monitoring upon participation in the network.
    ii. Upon completion of the credentialing process, the PA may be listed in the company provider directories. As with all providers, this listing will accurately reflect their specific licensure designation, and these providers will be subject to the audit process.
    iii. PA's will be clearly identified:
        1. On the credentialing file.
        2. At presentation to the Credentialing Committee.
        3. On notification to Network Services and to the provider database.

HDO eligibility criteria

All HDOs must be accredited by an appropriate, recognized accrediting body. In the absence of such accreditation, Anthem may evaluate: 1) the most recent site survey by Medicare, 2) the appropriate state oversight agency, or 3) a site survey performed by a designated independent external entity within the past 36 months. Nonaccredited HDOs are subject to individual review by the CC and will be considered for covered individual access need only when the CC review indicates compliance with Anthem standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are recredentialed at least every three years to assess the HDO's continued compliance with Anthem standards.

I. General criteria for HDOs:
    a. Valid, current, and unrestricted license to operate in the state(s) in which it will provide services to covered individuals (Note: The license must be in good standing with no sanctions.)
    b. Valid and current Medicare certification
    c. Must not be currently federally sanctioned, debarred or excluded from participation in Medicare, Medicaid or the FEHBP (Note: If exclusion from Medicare, Medicaid or FEHBP occurs to a participating HDO, the HDO will become immediately ineligible for participation in the

applicable government programs or provider network(s), as well as in our other credentialed provider network(s), at the time of identification. Special consideration regarding the HDO's continued participation in our other credentialed practitioner network(s) may be requested by the vice president (VP) responsible for that network(s) if, in the opinion of the requesting VP, the following criteria are met: the federal sanction, debarment or exclusion is not reflective of significant issues of professional conduct and competence, and participation of the HDO is important for network adequacy. The request with supporting information will be brought to Anthem's geographic credentials committee for consideration and final determination, without HDO appeal rights related to the special consideration, regarding the HDO's continued participation in Anthem's other credentialed provider network(s), if such participation would be permitted under applicable state regulation, rule or contract requirements.

d. Liability insurance acceptable to Anthem
e. If not appropriately accredited, the HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if Anthem's quality and certification criteria standards have been met.

II. Additional Participation Criteria for HDO by Provider Type:

HDO type and anthem approved accrediting agent(s)

Medical facilities

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Acute Care Hospital	CIQH, CTEAM, DNV/NIAHO, HFAP, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC
Birthing Center	AAAHC, CABC, TJC
Home Health Care Agencies (HHA)	ACHC, CHAP, CTEAM , DNV/NIAHO, TJC
Home Infusion Therapy (HIT)	ACHC, CHAP, CTEAM, HQAA, TJC
Skilled Nursing Facilities/Nursing Homes	CARF, TJC

Behavioral health

Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinics	CARF, CHAP, COA, HFAP, TJC

Facility Type (Behavioral Healthcare)	Acceptable Accrediting Agencies
Acute Care Hospital — Psychiatric Disorders	CTEAM, DNV/NIAHO, HFAP, TJC
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, TJC
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Abuse	ACHC, CARF, COA, DNV/NIAHO, TJC

Facility Type (Behavioral Healthcare)	Acceptable Accrediting Agencies
Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinics	CARF, CHAP, COA, HFAP, TJC
Partial Hospitalization/Day Treatment — Psychiatric Disorders and/or Substance Abuse	CARF, DNV/NIAHO, HFAP, TJC
Residential Treatment Centers (RTC) — Psychiatric Disorders and/or Substance Abuse	CARF, COA, DNV/NIAHO, HFAP, TJC

Rehabilitation

Facility Type (Behavioral Healthcare)	Acceptable Accrediting Agencies
Acute Inpatient Hospital — Detoxification Only Facilities	CTEAM, DNV/NIAHO, HFAP, TJC
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC
Outpatient Substance Abuse Clinics	CARF, TJC, COA,

Chapter 14: Access standards and access to care

Chat with Payer: Log onto **Availity.com** and from Payer Spaces select Chat with Payer.
Provider Services: **855-558-1443**
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.

Overview

This chapter outlines Anthem's 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 Wisconsin Department of Health Services (DHS), 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.

We recognize that cultural and linguistic barriers may affect our members' ability to understand or comply with certain instructions or procedures. To break through those barriers and ensure that our access standards can be met, we encourage providers to access Anthem's Caring for Diverse Populations Toolkit and Cultural Competency Training. Locate this information on our website at **https://providers.anthem.com/WI** under *Provider Training Academy* and scroll down to *Cultural Competency Resources*. Or for additional information on cultural diversity and interpreter services, please refer Culturally and Linguistically Appropriate Services in this manual.

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

General appointment scheduling

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

Nature of visit	Appointment standards
Emergency examinations	Immediate access 24 hours a day, 7 days a week
Urgent examinations	Within 24 hours of request
Routine exams	Within 14 days of request
Behavioral health emergency	Immediately
Outpatient treatment post-psychiatric inpatient care	Within three days from the date of discharge from an inpatient psychiatric hospital stay
Routine behavioral health visits dental care appointment standards routine dental appointment	Within ten days of request Within 90 days of request in Regions 5 and 6

Services for members under 21 years of age

Anthem strongly recommends that our members see their PCP as soon as possible after enrollment.

Nature of visit	Appointment standards
Initial health assessments	Newborns: Within 14 days of enrollment Children: Within 60 days of enrollment Adults (18-21): Within 90 days of enrollment
Preventive care visits	According to the American Academy of Pediatrics (AAP) Periodicity Schedule, found within the preventive health guidelines

Services for members 21 years of age and older

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

Prenatal and postpartum visits

Nature of visit	Appointment standards
First and second trimester	Within 14 days of request
Third trimester	Within five business days of request or immediately if an emergency
High-risk pregnancy	Within 14 days of request or immediately if an emergency
Postpartum exam	7-84 days after delivery

General appointment scheduling	
PCPs and specialists (including Oncologists) must make appointments for members according to the following scheduling standards:	
Nature of visit	Appointment standards
Emergency examinations	Immediate access 24 hours a day, 7 days a week
Urgent examinations	Within 24 hours of request
Routine exams	Within 30 days of request
High risk prenatal care	Within 14 days of request
Behavioral health emergency	Immediately
Outpatient treatment post-psychiatric inpatient care	Within three days from the date of discharge from an inpatient psychiatric hospital stay
Routine behavioral health visits dental care appointment standards routine dental appointment	Within 30 days of request Within 90 days of request in Regions 5 and 6
Dental care appointments	Within 90 days; Emergent within 24 Hrs

Wait times

When a provider's office receives a call from an Anthem member during regular business hours for assistance and possible triage, the provider or another healthcare professional must take or return the call within 30 minutes.

Nondiscrimination and office hours

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

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

Interpreter services

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

- Providers call Provider Services: **855-558-1443**

- Members call Member Services: **855-690-7800**

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

- Phone: **855-690-7800** (24 hours a day, 7 days a week)
- TTY: **711**

Please note: To schedule face-to-face interpreter services, please allow 72 hours. To cancel, please provide 24-hour notice.

Missed appointment tracking

When members miss appointments, providers must do the following:

- Document the missed appointment in the member's medical record.
- Make at least three attempts to contact the member to determine the reason for the missed appointment.
- Provide a reason in the member's medical record for any delays in performing an examination, including refusals by the member.

After-hours services

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

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

Answering service

Answering service or after-hours personnel must:

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

Answering machine messages:

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

We offer the following suggested text for answering machines:

"Hello, you have reached [insert physician office name]. If this is an emergency, hang up and dial 911 or go to the nearest hospital emergency room. If this is not an emergency and you have a medical concern or question, please call [insert contact phone or pager number]. You will receive a return call from the on-call physician within [time frame]."

Please note: Anthem prefers that PCPs use an in-network provider for on-call services. When this is not possible, PCPs must use their best efforts to ensure the covering on-call provider abides by the terms of the Provider Agreement.

24/7 NurseLine

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

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

Phone: **855-690-7800**
TTY: **711**

Continuity of care

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

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

Qualifying conditions include but are not limited to:

- Acute conditions (for example, cancer).
- Degenerative and disabling conditions or diseases caused by a congenital or acquired injury or illness requiring a specialized rehabilitation program or a high level of service, resources or coordination of care in the community.
- Newborns who are covered retroactive to the date of birth.
- Organ transplant or tissue replacement.
- Pregnancy, with 12 weeks or less remaining before the expected delivery date through immediate postpartum care.
- Scheduled inpatient/outpatient surgery that was approved and/or precertified through the applicable DHS process.
- Serious chronic conditions (hemophilia, for example).
- Terminal illness.

States of transition may be when the member is:

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

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

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

The HMO assigns a representative to coordinate services with public health agencies or treatment programs within the HMO's service area that are not included in the HMO's network. These include county health agencies, crisis intervention agencies, community support programs, comprehensive community service programs or inpatient programs. The HMO works with the agency to coordinate the member's transition to or from covered mental health and substance abuse care within the HMO's network. Any member transitioning from crisis intervention services may access an appropriate level of ongoing care within 30 days of the crisis. The HMO is not required to pay for ongoing services outside the HMO network, unless the HMO has authorized those services.
Providers must maintain accurate and timely documentation in the member's medical record, including but not limited to:

- Consultations
- Precertifications
- Referrals to specialists
- Treatment plans

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

Please note: Only Anthem can make adverse determination decisions regarding continuity of care. Adverse determination decisions are sent in writing to the member and provider within two business days of the decision. Members and providers may appeal the decision by following the procedures in **Chapter 12: Grievances and appeals.** Reasons for continuity-of-care denials include but are not limited to:

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

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

Provider contract termination

Anthem will arrange for continuity of care for members affected by a provider whose contract is terminated. A terminated provider actively treating members must continue to treat members until the date of termination. PCPs must give at least a 90-day advance notice, and specialists must give at least a 120-day advance notice before terminating the Provider Agreement. The exception is when the PCP or primary care clinic (PCC) provides 30% or more of Anthem services, in which case the PCP or PCC must give at least a 120-day advance notice.

After Anthem receives a provider's notice to terminate a contract, we notify all impacted members. We send a letter at least 30 days in advance to inform the affected members about the:

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

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

Newly enrolled members

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

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

Payment to out-of-network providers is made within the same time period required for providers within the network. In addition, we comply with out-of-network provider reimbursement rules as adopted by the DHS. All new enrollees receive evidence-of-coverage (EOC) membership information in their enrollment packets, which provides information regarding members' rights to request continuity of care.

Members moving out of the service area

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

Second opinions

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

Emergency transportation

Anthem covers emergency transportation services without precertification when a member's condition is life-threatening and requires use of special equipment, life support systems and close monitoring by trained attendants while en route to the nearest appropriate facility.

Emergency transportation also is available for facility-to-facility transfers when the required emergency treatment is not available at the first facility.

Emergency dental services for adults and children

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

Chapter 15: Provider roles and responsibilities

Chat with Payer: Log onto **Availity.com** and from Payer Spaces select Chat with Payer.
Provider services: **855-558-1443**
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.

Primary care physicians

PCPs are the principal point of contact for our members. The PCP's role is to provide members with a medical home. Anthem furnishes PCPs with a current list of assigned members. The PCP's role is to:

- Provide or arrange for routine and preventative healthcare service.
- Make referrals for specialty care and other medically necessary services.
- Maintain members' current medical records, including documentation of all services provided by the PCP, specialists or referral services.
- Adhere to the appointment wait time standards outlined in the Provider Agreement.
- Facilitate Interpreter Services by presenting information in a language that our members or their representatives can understand.

PCPs are required to ensure their members' medical and personal information is kept confidential as required by state and federal laws.

Out-of-network referrals

We recognize that an out-of-network referral may be justified at times. The Anthem Medical Management department will work with the Provider to determine medical necessity and will authorize out-of-network referrals on a limited basis. For assistance, contact the Medical Management department:

- Phone: **855-558-1443**
- Fax: **800-964-3627**

Interpreter services

Providers must notify members of the availability of interpreter services. Over the phone and face-to-face interpreter services are available at no cost to providers or members. Anthem providers should strongly discourage the use of minors, friends and family members acting as Interpreters. Refer to the "Culturally and Linguistically Appropriate Services" chapter for further details on interpreter services.

Providers must train their answering services and on-call personnel on how to access interpreter services and accommodate non-English speaking members by having multilingual messages on answering machines.

Provider and Facility Digital Guidelines

Anthem understands that working together digitally streamlines processes and optimizes efficiency. We developed the Provider and Facility Digital Guidelines to outline our expectations and to fully inform Providers and Facilities about our digital platforms. Anthem expects Providers and Facilities will utilize digital tools, unless otherwise prohibited by law or other legal requirements.

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

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

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

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

Digital guidelines available through Availity Essentials include:

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

Additional digital applications available to Providers and Facilities include:

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

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

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

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

Section 1: Accepting digital ID cards

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

Section 2: Eligibility and benefits inquiry and response

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

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

cycle management software and some EMR software. Contact Availity for available vendor integration opportunities.

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

- EDI transaction: X12 278 – prior authorization and referral:
    - Anthem supports the industry standard X12 278 transaction for prior authorization submission and status inquiry as mandated per HIPAA.
- EDI transaction: X12 275 – patient information, including HL7 payload for authorization attachments:
    - Anthem supports the industry standard X12 275 transaction for electronic transmission of supporting authorization documentation including medical records via the HL7 payload.
- Availity Essentials:
    - Authorization applications include the Availity Essentials multi-payer Authorization and Referral application for authorization submissions not accepted through Availity Essentials' multi-payer application.
        - Both applications enable prior authorization submission, authorization status inquiry and the ability to review previously submitted authorizations.
- Provider desktop integration via B2B APIs:
    - Anthem has enabled real-time access to prior authorization APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

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

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

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

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

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

Section 5: Electronic remittance advice and electronic claims payment

Electronic remittance advice

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

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

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

Electronic claims payment

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

Electronic Funds Transfer (EFT)

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

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

Virtual Credit Card (VCC)

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

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

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

- To opt out of virtual credit card payments, call **800-833-7130** and provide your taxpayer identification number.
- **Zelis Payment Network (ZPN) electronic payment and remittance combination**

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

Note that Anthem may receive revenue for issuing ZPN.
ERA through Availity is not available for Providers and Facilities using ZPN.
To disenroll from ZPN payment, there are two (2) options:

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

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

Submitting Provider demographic data requests and roster submissions through Roster Automation

Use the Provider Data Management (PDM) application on Availity Essentials to verify and initiate care provider demographic change requests for all professional and facility care providers*. **Going forward, the PDM application is now the preferred intake tool for care providers to submit demographic change requests, including submitting roster uploads.** If preferred, Providers may continue to utilize the Provider Enrollment application in Availity Essentials to submit requests to add new practitioners under existing groups for available provider types.

Within the PDM application, Providers have the choice and flexibility to request data updates via the standard PDM experience or by submitting a spreadsheet via a roster upload.

Roster Automation is our new technology solution designed to streamline and automate provider data additions, changes, and terminations that are submitted using a standardized Microsoft Excel document. Any provider, whether an individual provider/practitioner, group, or facility, can use Roster Automation today:**

The resources for this process are listed below and available on our website. Visit **https://providers.anthem.com/wi**, then under For Providers, select Forms and Guides. The **Roster Automation Rules of Engagement** and **Roster Automation Standard Template** appear under the Digital Tools category.

- **Roster Automation Rules of Engagement**: Is a reference document, available to ensure error-free submissions, driving accurate and more timely updates through automation.
- **Roster Automation Standard Template:** Use this template to submit your information. More detailed instructions on formatting and submission requirements can also be found on the first tab of the Roster Automation Standard Template (*User Reference Guide*).
- Upload your completed roster via the Availity PDM application.

Accessing PDM Application:
Log onto **availity.com** and select **My Providers > Provider Data Management** to begin the attestation process. 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** (see screen shot below) and follow the prompts.

Availity Administrators will automatically be granted access to PDM. Additional staff may be given access to **Provider Data Management** by an administrator. To find your administrator, go to **My Account Dashboard > My Account > Organization(s) > Administrator Information**.

***** Exclusions:

- Behavioral Health providers contracted with Carelon Behavioral Health who will continue to follow the process for demographic requests and/or roster submissions, as outlined by Carelon Behavioral Health.
- Any specific state mandates or requirements for provider demographic updates

****** If any roster data updates require credentialing, your submission will be routed appropriately for further action.

Transitioning members between medical facilities and home

When medically indicated, the PCP initiates or assists with the discharge or transfer of members:

- From an inpatient facility to the appropriate skilled nursing or rehabilitation facility, or to the member's home.
- From an out-of-network hospital to an in-network hospital or to the member's home with home healthcare assistance (within benefit limits).

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 Anthem Medical Management department to assist in this process.

Notification of admission and services

The hospital must notify Anthem or the review organization of an admission or service 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 Anthem of the admission or service the morning of the next business day.

Notification of precertification decisions

If the hospital has not received notice of precertification at the time of a scheduled admission or service as required by the utilization management guidelines and Hospital Agreement, the hospital should contact Anthem and request the status of the decision.

Any admission or service requiring precertification that has not received the appropriate review may be subject to post-service review denial. Generally, providers are required to perform all precertification functions with Anthem. Before rendering services, the hospital must ensure precertification has been granted or risk post-service denial.

After-hours services

All PCPs must have an after-hours system in place to ensure that our 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 provider or instruct the member that the provider will be in contact within 30 minutes.

Emergencies

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 directed to dial 911 or to proceed to the nearest hospital emergency room immediately.

If the PCP's staff or answering service is not 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 also must give members an alternative contact number to reach the PCP or on-call provider with medical concerns or questions.

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 to the nearest hospital emergency room immediately. In a nonemergency situation, members should receive instructions on how to contact the on-call provider. If an answering service is used, the service should know where to contact a telephone Interpreter. All calls taken by an answering service must be returned.

Network on-call providers

Anthem prefers that PCPs use network providers for on-call services. When that is not possible, the PCP must ensure that the covering on-call provider or other provider abides by the terms of the Provider Agreement. Anthem will monitor PCP compliance with after-hours access standards on a regular basis. Failure to comply may result in corrective action.

24/7 NurseLine

Members may call our 24/7 NurseLine information line 24 hours a day, 7 days a week to speak to a registered nurse. These nurses provide health information regarding illness, options for accessing care and availability of emergency services.
Phone: **855-690-7800**
TTY: **711**

Licenses and certifications

Providers must maintain all licenses, certifications, permits, accreditations or other prerequisites required by Anthem and federal, state and local laws for providing medical services.

Eligibility verification

All providers must verify member eligibility immediately before providing services, supplies or equipment. Because eligibility may change monthly, a member eligible on the last day of the month may not be eligible on the first day of the following month. Anthem is not responsible for charges incurred by ineligible patients.

Verify member eligibility

To verify member eligibility, log on to Availity at **https://www.availity.com**.*From Availity's homepage, select **Patient Registration > Eligibility & Benefits**.

Continuity of care

PCPs are responsible for being an ongoing source of primary care appropriate to the member's needs. We have established comprehensive mechanisms to ensure continued access to care for members when providers leave our healthcare program. Under certain circumstances, members may finish a course of treatment with the terminating provider. For more information, refer to **Chapter 14: Access standards and access to care**.

Medical records standards

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

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

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

Records required through a legal instrument may be released without patient or patient representative consent. Providers must be familiar with the security requirements of *the Health Insurance Portability and Accountability Act of 1996 (HIPAA)* and be in compliance. For more information on medical records standards, refer to **Chapter 18: Quality Assessment and Performance**.

Mandatory reporting of child abuse, elder abuse or domestic violence

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

Updating provider demographic information

Demographic changes should be submitted using Anthem's online *Provider Maintenance Form*, which is state-specific and available on the Availity Essentials. Providers are required to inform Anthem of any changes to their practice profile, including:

- Adding or changing a business address or location where services are provided.
- Name change.
- Tax ID change.
- Provider leaving a group or a single location.
- Changing phone/fax number.
- Closing a practice location.

- Change in specialty.
- Services offered to children.
- Languages spoken.
- Notification that the provider is accepting new patients.

Providers can call Provider Services at **855-558-1443** to notify Anthem of:

- Legal or governmental action initiated against a healthcare professional. (Note: This type of action includes but is not limited to: an action for professional negligence, for 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 impair the ability of the healthcare professional to carry out the duties and obligations under the *Provider Agreement's* care review and grievance resolution procedures.

Oversight of nonphysician practitioners

All providers using nonphysician practitioners must supervise and oversee nonphysician practitioners consistent with state and federal laws. The supervising provider and the nonphysician practitioner must have written guidelines for adequate supervision. All supervising providers must follow state licensing and certification requirements. Nonphysician practitioners include the following categories:

- Nurse practitioners
- Certified nurse midwives
- Physician assistants

These nonphysician practitioners are licensed by the state and work under the supervision of a licensed physician, as mandated by state and federal regulations.

Open clinical dialogue/affirmative statement

Nothing within the Provider Agreement or this manual should be construed as encouraging providers to restrict medically necessary covered services or limit clinical dialogue between providers and their patients. Providers may communicate freely with members regarding the available treatment options, including medications, regardless of benefit coverage limitations.

Provider contract termination

A terminated provider actively treating members must continue treatment until the termination date. The termination date is the end of the 90-day period following written notice of termination, or according to a timeline determined by the medical group contract.

After we receive a provider's notice to terminate a contract, we notify members impacted by the termination 30 days prior to the termination. Anthem sends a letter to inform affected members about the:

- Impending termination of their provider.
- Member's right to request continued access to care.
- Member Services phone number to request PCP changes.
- Referrals to Medical Management for continued access-to-care consideration.

Members under the care of specialists also may submit requests for continued access to care, even after the transition period, by calling Member Services:
Phone: **855-690-7800**
TTY: **711**

Anthem may terminate the Provider Agreement if we determine that the quality of care or services given by a healthcare provider is not satisfactory. We make this determination by reviewing member satisfaction surveys, case management data, member complaints or grievances, other complaints or lawsuits alleging professional negligence, or quality of care indicators.

Termination of the ancillary provider/patient relationship

Under certain circumstances, an ancillary provider may terminate the professional relationship with a member, as provided for and in accordance with the provisions of this manual. However, 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.

Disenrollees

When a member disenrolls and requests a transfer to another health plan, providers are expected to work with Anthem case managers responsible for helping 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 will coordinate with the member, the member's providers and the case manager at the new health plan to ensure an orderly transition.

Provider rights

Anthem providers, acting within the lawful scope of practice, will not be 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, self-administered treatment
- Any information the member needs 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
- To receive information on the grievances and appeals and state fair hearing procedures
- To have access to policies and procedures covering authorization of services
- To be notified 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 our 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 or her license or certification under applicable law, solely based on that license or certification

Prohibited activities

All providers are prohibited from:

- Segregating members in any way from other persons receiving similar services, supplies, or equipment.
- Discriminating against Anthem members.
- Recommending one HMO over another, offering patients incentives, offering patients incentives to select one HMO over another HMO, or assisting the patient in deciding to select a specific HMO.

Prohibition on Billing Members for Covered Services

- Providers and subcontractors shall not bill a member for covered services in the benefit package provided during the member's enrollment period with Anthem except if the Anthem elects to charge copays to members as required under Sections 1916A(a)(2)(B), 1916A(b)(1)(B)(ii), and 1916A(b)(2)(A) of the Social Security Act, as implemented in 42 CFR § 447.56 (f)).
- This provision applies even if one or more of the following exists:
  a. Anthem becomes insolvent;
  b. The Department of Health Services (DHS) does not pay Anthem for covered services provided to

the member;
c. DHS or Anthem does not pay the provider that furnishes the services under a referral or other arrangement; and
d. Payment for services furnished under a subcontract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if Anthem provided the service directly.

DHS policies related to Medicaid Managed Care program provider

Per DHS's HMO and PHIP Communication, Outreach and Marketing Guide, the following outlines the polices relevant for providers:

- Providers may educate and inform their patients about the Health Plan's with which the contract.
- Providers may inform their patients of the benefits, services, and specialty care services offered through the Health Plan in which they participate.
- Providers may give a member contact information for a particular Health Plan, but only at the member's request.
- Providers are allowed to assist potentially eligible individuals with enrollment in the Medicaid managed care program by helping them:
    - Apply online at the Access website: **www.access.wisconsin.gov**;
    - Complete the online form at: **www.dhs.wisconsin.gov/forms/F1/F10182.pdf**; or
    - Call or go to their county IM agency or tribal agency to complete an application; for a map of the different IM agencies per county, go to: **www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm**
- Providers are allowed to assist potentially eligible individuals with the BadgerCare Plus express enrollment process, as described on the ForwardHealth Portal at **www.forwardhealth.wi.gov**, if they qualify.
- Providers are allowed to refer patients with questions about the BadgerCare Plus and/or Medicaid SSI programs to an HMO Enrollment Specialist at **800-291-2002**.
- Health Plans are allowed to conduct orientations, health fairs, or community baby showers for their members in a private setting at a provider's office.
- D-SNP plans are allowed to have agreements with providers in connection with plan marketing activities as long as the activity is consistent with Medicare regulations. D-SNP plans may use providers/and or facilities to distribute plan marketing materials as long as the provider and/or the facility distributes marketing materials for all plans with which the provider participates.
- Providers are prohibited from recommending one HMO over another HMO, offering patients incentives to select one HMO over another HMO, or assisting the patient in deciding to select a specific HMO.
- Per the Medicare Marketing Guidelines, providers participating in D-SNP plans must remain neutral when assisting members with enrollment decisions to ensure that providers do not appear to be a D-SNP plan agent.

Misrouted Protected Health Information

You are not permitted to use or disclose protected health information about individuals you are not treating or have enrolled to your practice. This applies to protected health Information accessible in any Anthem online tool, or sent in any medium including mail, email, fax or other electronic transmission.

Chapter 16: Clinical practice and preventive healthcare guidelines

Chat with Payer: Log onto **Availity.com** and from Payer Spaces select Chat with Payer.
Provider Services: **855-558-1443**
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.

Overview

At Anthem, we believe that providing quality healthcare should not be limited to the treatment of injury or illness. We are committed to helping providers and members become more proactive in the quest for better overall health. To accomplish this goal, we offer providers tools to assist in finding the best, most cost-effective ways to:

- Provide member treatment.
- Empower members through education.
- Encourage member lifestyle changes when possible.

We want providers to have access to the most up-to-date clinical practice and preventive healthcare guidelines, offered by nationally recognized healthcare organizations and based on extensive research. These guidelines include the latest standards for treating the most common and serious illnesses, such as diabetes and hypertension. These guidelines also include recommendations for preventive screenings, immunizations and member counseling based on age and gender.

Clinical practice guidelines

Providers need the latest research on treating common conditions, such as asthma, diabetes, and hypertension. The clinical practice guidelines follow nationally-recognized best practices for standards of treatment and give providers a powerful tool in educating our members. The clinical practice guidelines are available on our provider website at **https://providers.anthem.com/WI** > Resources> Policies, Guidelines and Manuals > Clinical Practice Guidelines. The website offers the most up-to-date clinical resources and guidelines.

Please note: Our recommendation of these guidelines is not an authorization, certification, explanation of benefits or a contract. Actual member benefits and eligibility for services are determined in accordance with the requirements set forth by the state.

Preventive healthcare guidelines

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

The preventive healthcare guidelines, offered by nationally-recognized health organizations as a provider resource, are an effective tool for improving the overall health of our members by emphasizing education and behavior change. The guidelines can be accessed from the Anthem provider website under the quick link Members > Get Help > Health & Wellness > Preventive Health Guidelines.

Please note: Our recommendation of these guidelines is not an authorization, certification, explanation of benefits, or a contract. Actual member benefits and eligibility are determined in accordance with the requirements set forth by the state.

Chapter 17: Case management

Case Management:	**844-238-4048**
Hours of operation:	Monday to Friday, 8 a.m. to 5 p.m.
Website:	**https://providers.anthem.com/WI**

Overview

Our Case Management program is a collaborative effort providing assistance to both providers and members in the coordination of complex healthcare. The program is designed to educate and assist members to become empowered, exercise their options to access the appropriate services, and optimize their healthcare benefits to meet their individual health needs. This includes Case Management staff working one-on-one with members, their families, and other members of the interdisciplinary care team, using behavioral health science to promote engagement.

A case manager will perform an assessment to identify the needs of the member. In collaboration with the member, a care plan is developed. Barriers are identified within the care plan, and goals are developed to work through the barriers. The case manager will periodically re-evaluate progress toward goals and address any new issues. A copy of the care plan is sent to the provider for review. After the goals are met or Case Management can no longer make an impact, the case is closed, and the provider is notified of the case closure. Cases referred to Case Management may be identified by disease or condition, dollars spent, or high utilization of services.

Please note: Our Case Management department is sensitive to the cultural and linguistic diversity of our members and its impact on their interaction in the healthcare system. We encourage providers to become familiar with our cultural and linguistic training materials, available on the providers page of our website: **https://providers.anthem.com/WI**. There are interpreters available to meet the needs of our members. If the provider requests an interpreter to be present at the time of the appointment with the member, Anthem makes the arrangements. Contact Provider Services at **855-558-1443**.

Provider responsibilities

PCPs have the responsibility of participating in the case management process by sharing information and facilitating the process as follows:

- Referring members who could benefit from case management
- Sharing information as soon the PCP identifies complex healthcare needs
- Collaborating with case management staff on an ongoing basis
- Referring members to specialists, as required
- Providing medical information
- Monitoring and updating the care plan to promote healthcare goals
- Coordinating county or state-linked services such as public health, behavioral health, schools and waiver programs

Referral process

Providers, nurses, social workers, and members or their representatives may refer members to Case Management by calling **844-238-4048**.

Case manager responsibilities

The case managers will work together with the member and primary care provider as a team to provide appropriate services to the member. The case manager will 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 provider(s) about care management, community resources, benefits, cost factors and all related topics so informed decisions may 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.

The Case Management department includes experienced and licensed registered nurses and behavioral health professionals, some of whom are certified case managers. The department also includes social workers who add valuable skills, allowing us to address our members' medical, psychological, social and financial issues.

Continued access to care

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

Continuity of care process

Our case management team reviews member and provider requests for continuity of care. This team facilitates continuation with the current provider until the short-term regimen of care is complete or the member transitions to a new provider.

Chapter 18: Quality assessment and performance improvement

Chat with Payer: Log onto **Availity.com** and from Payer Spaces select Chat with Payer.
Provider Services: **855-558-1443**
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.

Overview

Anthem's goal is continuous, measurable improvement in our delivery of quality healthcare. Following federal and state guidelines, we have a Quality Assessment and Performance Improvement (QAPI) program in place to advance our levels of readiness, service, and care. The QAPI program, aligned with the state of Wisconsin's quality standards, includes focused studies measuring quality of care in the following clinical and service areas:

- Well Child First 30 months
- Well Child Visit 3 -21 years
- Childhood Immunizations
- Immunizations for Adolescents
- Lead Screening for Children
- Prenatal Timeliness
- Post-partum Care
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
- Follow-Up After Emergency Department Visit for Mental Illness
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
- Follow- Up After Hospitalization for Mental Illness

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

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

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

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

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

Anthem uses the HEDIS data to identify areas for improvement and shares the results with providers. We submit the results of the HEDIS assessment and our own quality studies annually to the Wisconsin Department of Health Services (DHS), which makes the results public. As a result, HEDIS summaries may be used by potential members to make comparisons before choosing a healthcare plan.

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

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

Quality assessment and performance improvement program

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

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

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

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

An overview of the QAPI program outcomes is posted on the provider website annually. You may also request a hard copy by calling Provider Services at **855-558-1443**.

Healthcare Effectiveness Data and Information Set

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

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

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

Quality management

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

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

Best practice methods

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

- Resources for improving compliance with preventive health services
- Clinical practice guidelines
- Care for members with special or chronic care needs

Member satisfaction surveys

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

- Access to care
- Anthem customer service
- Provider communications
- Provider office staff performance

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

Provider satisfaction surveys

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

Medical records and facility site reviews

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

- Compliance with standards for providing healthcare.
- Compliance with standards for storing medical records.
- Compliance with processes that maintain safety standards and practices.
- Involvement in the continuity and coordination of member care.

Please note: The Wisconsin DHS and Anthem have the right to enter the premises of providers to inspect, monitor, audit or otherwise evaluate the work performed. We perform all inspections and evaluations in such a manner as to not unduly delay work, in accordance with the Provider Agreement.

Medical record documentation standards

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

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

Medical record security

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

Storage and maintenance

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

Availability of medical records

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

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

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

Providers must supply a copy of a member's medical record upon reasonable request by the member at no charge. The provider also must facilitate the transfer of the member's medical record to another provider at the member's request. Access to medical records and confidentiality must be provided in accordance with the standards mandated in *HIPAA* and all other state and federal requirements.

Providers must permit Anthem and ForwardHealth representatives to review members' medical records for the purposes of monitoring the provider's compliance with the medical record standards, capturing information for clinical studies, monitoring quality or any other reason. ForwardHealth encourages providers to use technology, such as health information exchanges, to transmit and store medical record data.

Medical record requirements

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

- The patient's name or identification (ID) number on each page in the record
- Personal biographical data, including home address, employer, emergency contact name and phone number, home and work phone numbers, and marital status
- Entries dated with month, day and year
- Entries documented with the author's identification and title; for example, handwritten signature, unique electronic identifier or initials
- Identification of all providers participating in the member's care
- Information on the services furnished by these providers
- List of problems, including significant illnesses, medical conditions and psychological conditions

- Presenting complaints, diagnoses and treatment plans, including the services to be delivered
- Physical findings relevant to the visit, including vital signs, normal and abnormal findings, and appropriate subjective and objective information
- Information on allergies and adverse reactions or a notation that the patient has no known allergies or history of adverse reactions
- Information on advance directives
- Past medical history, including serious accidents, operations and illnesses; in addition:
    - For patients 14 years old and older, the record must include information about substance abuse.
    - For children and adolescents, the record must include past medical history as it relates to prenatal care, birth, operations and childhood illnesses.
- Notations concerning the use of cigarettes, alcohol and substance abuse for patients 14 years and older, including anticipatory guidance and health education
- Physical examinations, treatment necessary and possible risk factors relevant to the particular treatment
- Prescribed medications, including dosages and dates of initial or refill prescriptions
- Information about the individuals to be instructed in assisting the patient
- Medical records legible, dated and signed by the provider, physician assistant, nurse practitioner or nurse midwife providing patient care
- Up-to-date immunization record for children, or an appropriate history for adults
    - Documentation of attempts to provide immunizations (If the member refuses immunization, proof of voluntary refusal of the immunization in the form of a signed statement by the member or guardian shall be documented in the member's medical record.)
    - Evidence of preventive screening and services, in accordance with Anthem 's preventive health practice guidelines
    - Documentation of referrals, consultations, diagnostic test results and inpatient records (Evidence of the provider's review may include the provider's initials or signature and notation in the patient's medical record. The provider may indicate review and patient contact, follow-up treatment, instructions, return office visits, referrals, and other patient information.)
    - Notations of patient appointment cancellations or no-shows and the attempts to contact the patient to reschedule
    - No indication or implication that the patient was placed at inappropriate risk by a diagnostic test or therapeutic procedure
    - Documentation on whether an interpreter was used in any initial or follow-up visit

Advance directives

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

- Discuss the sensitive issues raised by advance directives with patients and their families.
- Advise members of their right to change or revoke their advance directive at any time.
- Advise members of their right to contact Member Services to request additional information about advance directives.
- Document in the member's medical record the discussion about advance directives.
- Document in the member's medical record whether or not an advance directive has been completed.
- Place a copy of a completed advance directive in the member's medical record.

Medical record review process

A member of the Quality Improvement department may call the provider's office to schedule a medical record review on a date and time occurring within 30 days. On the day of the review, the quality improvement associate will:

1. Request the number and type of medical records required.
2. Review the appropriate type and number of medical records per provider.
3. Complete the medical record review.
4. Meet with the provider or office manager to review and discuss the results of the medical record review.
5. Provide a copy of the medical record review results to the office manager or provider or send a final copy within ten days of the review.
6. Schedule follow-up reviews for any corrective actions identified.

Providers must attain a score of 80% or greater to pass the medical record review. Anthem may conduct a medical record, according to our medical records standards, at select primary care sites and high-volume provider offices.

Facility site review process

An initial site inspection may be required for all provider offices participating in Anthem, regardless of other accreditation or certification. In addition:

- A site review is required as part of the initial credentialing process for new providers if that site has not been reviewed and accepted as part of Anthem's credentialing process.
- Obstetrics/gynecology (OB/GYN) specialist sites participating in our plan and not serving as PCPs also must undergo an initial site inspection.

After the facility site review is completed, our associate will meet with the provider or office manager to:

1. Review and discuss the results of the facility site review and explain any required corrective actions.
2. Provide a copy of the facility site review results and the corrective action plan to the provider or office manager or mail a final copy within 10 days of the review.
3. Educate the provider and office staff about our standards and policies.
4. Schedule a follow-up review for any corrective actions identified.

Facility site review: Corrective actions

If the facility site review results in a nonpassing score, Anthem will notify providers immediately of the nonpassing score, all cited deficiencies and corrective action requirements. The provider office will develop and submit corrective action plans, and we will conduct follow-up visits every six months until the site complies with our standards.

The provider and office staff will:

1. Make available an appointment time for the review.
2. Be available to answer questions and participate in the exit interview.
3. Schedule follow-up reviews, if applicable.
4. Complete a corrective action plan.
5. Sign an attestation that corrective actions are complete.
6. Submit the completed corrective action plan, supporting documents and signed attestation.

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 these events.

Providers and healthcare systems, as advocates for our members, are responsible for the continuous monitoring, implementation, and enforcement of applicable healthcare standards. Focusing on patient safety,

we work collaboratively with providers and hospitals to identify preventable adverse events and implement appropriate strategies and technologies to avoid these events. Our goal is to enhance the quality of care received not only by our members, but all patients receiving care in these facilities.

Prevention of adverse events may require the disclosure of protected health information (PHI). *HIPAA* specifies that PHI may be disclosed for the purpose of healthcare operations in relation to quality assessment and improvement activities. Moreover, the information you share with us is legally protected through the peer review process and will be maintained in a strictly confidential manner. If you receive a request for medical records, please provide the records within 10 days from the date of request.

We will continue to monitor activities related to the list of adverse events from federal, state and private payers, including never events.

Never events: As defined by the National Quality Forum (NQF), never events are 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, we firmly support the concept that a health plan and its members should not pay for resultant services.

Please note: Medicaid is prohibited from paying for certain healthcare acquired conditions (HCAC), and this ruling applies to all hospitals.

Chapter 19: Enrollment and marketing rules

Chat with Payer: Log onto **Availity.com** and from Payer Spaces select Chat with Payer.
Provider Services: **855-558-1443**
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.

Overview

The delivery of quality healthcare poses numerous challenges, not the least of which is the commitment shared by Anthem and providers to act in the best interest of our members. We want our members to make the best healthcare decisions possible. And when members ask for our assistance, we want to provide that assistance so they make those decisions without undue influence.

We recognize 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 of the populations we serve, there are potentially serious pitfalls when providers try to assist in the decision-making process. Sometimes, even though the intent is to help make our members' lives better, we may overstep.

For that reason, we are committed to following strict enrollment and marketing guidelines created by the Wisconsin Department of Health Services (DHS) and to honoring the rules for all state healthcare programs.

Enrollment policies

Anthem members enrolled in BadgerCare Plus and Medicaid SSI may change their choice of a healthcare plan during the first three months of enrollment, a process called open enrollment. After 90 days, when the open enrollment period is over, members cannot change their healthcare plan for nine more months. This is known as the lock-in period. Members will be sent a letter advising when their lock-in period will end. When the lock-in period is over, they may change to a different healthcare plan, if available. Most SSI and SSI -related Medicaid members are required to choose the HMO in which they wish to enroll.

Marketing policies

Anthem 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. The DHS marketing practice policies prohibit network providers from making any of the following false or misleading claims:

- PCP office staff are employees or representatives of the state, county, or federal government.
- Anthem is recommended or endorsed by any state or county agency, or any other organization.
- The state or county recommends that a prospective member enroll with a specific healthcare plan.
- A prospective member or medical recipient loses Medicaid or other welfare benefits if the prospective member does not enroll with a specific healthcare plan.

These policies also prohibit network providers from taking the following actions:

- Making marketing presentations, advising or recommending to an eligible individual that he or she select membership in a specific healthcare plan
- Offering or giving away any form of compensation, reward or loan to a prospective member to induce or procure member enrollment in a specific healthcare plan
- Engaging in direct marketing to members designed to increase enrollment in a particular healthcare plan (The prohibition should not constrain providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.)
- Using any list of members originally obtained 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 other than persons specifically excluded from coverage under our contract. Providers may not discriminate based on marital status, age, religion, gender, gender identity, national origin, language, sexual orientation,

ancestry, pre-existing psychiatric problem, or medical condition such as pregnancy, disability or acquired immune deficiency syndrome (AIDS)
- Reproducing or signing an enrollment application for the member
- Displaying materials only from the provider's contracted managed healthcare organizations and excluding others

Providers are permitted to:

- Assist members in applying for benefits by calling Anthem or the HMO enrollment specialist for enrollment information:
  - Phone: **855-690-7800**
  - TTY: **711**
  - Health Maintenance Organization (HMO) enrollment specialist: **800-291-2002**
- Distribute copies of BadgerCare Plus applications to potential members or refer potential members to **www.access.wisconsin.gov** (Medicaid SSI recipients automatically qualify for Medicaid, and therefore, would simply call the HMO enrollment specialist at **800-291-2002**).
- File a complaint with Anthem if a provider or member objects to any form of marketing, either by other providers or by Anthem representatives. Refer to **Chapter 12: Grievances and appeals** for more information on the grievance process.

Enrollment process

DHS determines the eligibility and enrollment for individuals seeking to enroll in BadgerCare Plus and Medicaid SSI, after which the process is as follows:

- DHS presents BadgerCare Plus Plan to eligible individuals and families.
- DHS informs Anthem of new member enrollment.
- Providers are given notice of new members assigned to their care through monthly eligibility reports. Providers access these reports by logging in to **Availity.com**, Anthem sends each new member a new member packet within ten business days of receiving the DHS monthly membership file. This packet includes information about the health plan and how to access services.

Please note: If a member loses BadgerCare Plus eligibility but becomes eligible again within six months or less, DHS automatically re-enrolls the member. DHS also returns the member automatically to the same healthcare plan and PCP they had prior to disenrollment, if available. Members may choose to switch plans if they are no longer locked in.

Chapter 20: Fraud, abuse, and waste

Both providers and members may report fraud, abuse and waste concerns by:

- Visiting our **www.fighthealthcarefraud.com** education site; at the top of the page click "Report it" and complete the ***Report Waste, Fraud and Abuse*** form
- Calling Provider Services: **855-558-1443 (**Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.)
- Calling Member Services phone: **855-690-7800 (**TTY: **711)**
- Contacting Special Investigations Unit (SIU):
- By phone: **866-847-8247** (TTY: **866-494-8279**)

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

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

Understanding fraud, abuse, and waste

Combating fraud, abuse and waste 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. The attempt itself is fraud, regardless of whether or not it is successful.

Abuse: Any practice inconsistent with sound fiscal, business, or medical practices that results in an unnecessary cost to the Medicaid program, including administrative costs from acts that adversely affect providers or members.

Waste: Generally defined as activities involving careless, poor or inefficient billing or treatment methods causing unnecessary expenses and/or mismanagement of resources.

Examples of provider fraud, abuse and waste

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

- Altering medical records
- Billing for services not provided
- Billing for medically unnecessary tests
- Billing professional services performed by untrained personnel
- Misrepresentation of 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

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

Examples of member fraud, abuse, and waste

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

- Forging, altering or selling prescriptions
- Letting someone else use a member's ForwardHealth identification (ID) card
- Not telling the truth about a medical condition to obtain medical treatment
- Not notifying the health plan when relocating to an out-of-service area
- Using someone else's ForwardHealth ID

Reporting provider or recipient fraud, abuse, or waste

If you suspect either a provider (doctor, dentist, counselor, etc.) or member (a person who receives benefits) has committed fraud, abuse or waste, you have the right and responsibility to report the incident.

Provider reporting

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

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.

When reporting about a provider, include the following:

- Name, address, and phone number of the provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if available
- 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

When reporting about a member who receives benefits, include the following:

- The person's name
- The person's date of birth, Member ID or case number, if available
- The city where the person lives
- Specific details about the fraud, abuse or waste

Investigation process

We investigate all reports of fraud, abuse and waste for all services provided to members. If appropriate, allegations and the investigative findings are reported to all appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, abuse, or waste, which may include, but is not limited to:

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

- *Recoveries*: We recover overpayments directly from the provider. Failure of the provider to return the overpayment may result in reduced payment of future claims and/or further legal action.

Please note: Providers are expected to follow proper coding and documentation procedures to support all claims submitted for reimbursement. Payment on claims should not be construed as being appropriate. The provider must retain and produce all documentation supporting the level of service submitted on a claim(s) upon request.

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

Use the information supplied in correspondence from SIU for submitting medical records and claims. If you have questions, contact your investigator. An opportunity to submit claims and medical records electronically is an option if you register are registered for Availity. Contact Availity Client Services at **800-AVAILITY (282-4548)** for more information.

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. Providers are required to repay any identified overpayments based on results of a medical record review per DHS 108.02(9) Failure to comply with program policy, procedures or any violation of the contract will result in termination from our plan.

If a member is suspected or has committed fraud, exhibited abusive or threatening behavior, or has failed to correct issues, they may be involuntarily disenrolled from our healthcare plan, with state approval. Refer to **Chapter 11: Member transfers and disenrollment**.

False Claims Act

We are committed to complying with all applicable federal and state laws, including the federal False Claims Act (FCA). The FCA is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the FCA, anyone who knowingly submits, or causes another person or entity to submit, false claims for payment of government funds is liable for three times the damages, or loss, to the government plus civil penalties of $5,500 to $11,000 per false claim.

The FCA also contains Qui Tam, or whistleblower, provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under Qui Tam provisions in the FCA and may be entitled to a percentage of the funds recovered by the government.

Employee education about the False Claims Act

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

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

Chapter 21: Member rights and responsibilities

Member Services: **855-690-7800** (TTY **711**)
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.

Overview

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

The following member rights and responsibilities are defined by the state of Wisconsin and appear in the member handbook.

Member rights

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

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

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

Members have the right to:

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

- Be free from any form of restraint or seclusion used as means of force, control, convenience, or retaliation.
- Request copies of their medical records from their providers.

Member responsibilities

Members have the responsibility to:

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

Chapter 22: Culturally and Linguistically Appropriate Services

Chat with Payer: Log onto **Availity.com** and from Payer Spaces select Chat with Payer.
Provider Services: **855-558-1443**
Provider Services fax: **800-964-3627**
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.

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

The U.S. Department of Health and Human Services (HHS) defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. It is a dynamic, ongoing developmental process requiring long-term commitment. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains that healthcare is defined through a cultural lens for both patients and providers. A person's cultural affiliations can influence:

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

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

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

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

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

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

- **Caring for Children with ADHD:** Promotes understanding of and adherence to diagnosis and treatment guidelines; use of AAP's Resource Toolkit for Clinicians; awareness of and strategies for addressing disparities.
- **My Inclusive Practice - Improving Care for LGBTQIA+ Patients:** Helps providers understand the fears and anxieties LGBTQIA+ patients often feel about seeking medical care, learn key health concerns of LGBTQIA+ patients, & develop strategies for providing effective healthcare to LGBTQIA+ patients.

- **Improving the Patient Experience:** Helps providers identify opportunities and strategies to improve patient experience during a healthcare encounter.
- **Medication Adherence:** Helps providers identify contributing factors to medication adherence disparities for diverse populations & learn techniques to improve patient-centered communication to support needs of diverse patients.
- **Moving Toward Equity in Asthma Care:** Helps providers understand issues often faced by diverse patients with asthma & develop strategies for communicating to enhance patient understanding.
- **Reducing Health Care Stereotype Threat (HCST):** Helps providers understand HCST and the implications for diverse patients as well as the benefits of reducing HCST to both providers' patients and practices, and how to do so.

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

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

Interpreter services

For those instances when you cannot communicate with a member due to language barriers, interpreter services are available at no cost to you or the member. Anthem provides over-the-phone and face-to-face interpreters. 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, are available by placing a request at least 72 hours in advance. A 24-hour cancellation notice is required. Request telephone interpreter services by calling:

- Providers: **855-558-1443**
- Members: **855-690-7800**
- 24/7 NurseLine (after-hours): **855-690-7800**

For after-hours interpreter services, call the 24/7 NurseLine and take the following steps:

1. Give the member's identification (ID) number to Member Services.
2. Explain the need for an interpreter and state the language required.
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 Anthem member, explains the reason for the call and begins the dialogue.

Request face-to-face interpreter services by calling:

- Providers: **855-558-1443**
- Members: **855-690-7800**

Services for members with hearing loss, visual and/or speech impairment

Members with hearing loss or speech impairment can call **711**. Members can also request face-to-face sign language interpreters at no cost. Members with visual impairments can request verbal assistance or alternative formats for assistance with printed materials at no cost.

Translation of materials

Members can request translation of materials into non-English languages at no cost by contacting Member Services: **855-690-7800**.

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

* Availity, LLC is an independent company providing administrative support services on behalf of the health plan.

***** DentaQuest is an independent company providing dental benefit management services on behalf of the health plan.

* ForwardHealth is an independent company providing dental, pharmacy, and transportation services on behalf of the health plan.

* March Vision Care is an independent company providing vision 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.

***** CERIS is an independent company providing claim service review on behalf of the health plan.

Provider Services: **855-558-1443**
https://providers.anthem.com/wi