Provider Manual

Medi-Cal Managed Care

Anthem

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Chapter 1: Introduction

Welcome

Thank you for being part of the Anthem family of healthcare services.

Anthem has been selected by the California Department of Health Care Services (DHCS) to provide healthcare services for Medi-Cal Managed Care (Medi-Cal) members in the following counties:

- Alpine
- Amador
- Calaveras
- El Dorado
- Fresno
- Inyo
- Kings
- Kern
- Madera
- Mono
- Sacramento
- San Francisco
- Santa Clara
- Tulare
- Tuolumne

Anthem partners with L.A. Care Health Plan to provide healthcare services for Medi-Cal members in Los Angeles county.

Medi-Cal provides healthcare coverage for California's most vulnerable low-income residents who lack health insurance.

Medi-Cal is the second largest source of healthcare coverage in California. Anthem has a long-standing history of providing Medi-Cal services to Californians. In fact, Anthem was one of the first Medi-Cal managed care organizations (MCOs).

California is constantly faced with threats including weather-related office closures, delays, facility evacuations, wildfires, floods, and earthquakes. Anthem is dedicated to delivering the best possible services to its members, even during an emergency. Part of preparing for an emergency event includes educating providers within our network on our emergency policies and procedures, response, and communication protocols. During an emergency, the Anthem provider website will be updated with information related to disaster processes.

Using this Manual

This provider manual is designed for Anthem contracted providers. Our goal is to create a useful reference guide for you and your office staff.

Anthem will solicit feedback from community stakeholders in various forums that can include the Community Advisory Committee (CAC) and Medical Advisory Committee (MAC) regarding the development of this manual and clarify new or revised policies and procedures it contains.

Providers contracted with an independent physician association (IPA) or other provider organization may have separate policies and procedures. Please contact the organization’s administrator for details.

We recognize that managing our members’ health can be a complex undertaking. It requires familiarity with the rules and requirements of a system that encompasses a wide array of healthcare services and responsibilities.

With that in mind, we have divided this manual into broad sections that reflect your questions, concerns, and responsibilities before and after a member of Anthem walks through your doors. This manual is available to you on our website at providers.anthem.com/CA.

Select any topic in the Table of Contents and you will be automatically redirected to that topic's location within the manual. Select any web address and you will be redirected to that site. Each section may also contain cross-links to other sections, important phone numbers, and our website or outside websites containing additional information.

Throughout this manual, there are instances where information is provided as a sample or example. This information is meant for illustration purposes only and is not intended to be used or relied upon in any circumstance or instance. If you have any questions about the content of this manual, please contact your provider relationship management representative.

Definitions

Provider: Any individual or entity that is engaged in the delivery of Medi-Cal services, or ordering or referring for those services, and is licensed or certified to do so.

Subcontractor: An individual or entity that has a Subcontractor Agreement with Anthem that relates directly or indirectly to the performance of Anthem's obligations under its contract with DHCS (for example: PMG/IPA).

All Plan Letter (APL): Operational guidance developed by the Department of Health Care Services to convey new or revised program policy as it relates to the administration of the Medi-Cal Program.

Legal and Administrative Requirements

Websites

The Anthem website and this manual may contain links and references to internet sites owned and maintained by third parties. 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 expressed or implied, to the fullest extent permitted under applicable laws.

Anthem disclaims all warranties, expressed 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.

The information contained in this manual 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.

This manual provides standards for services to members of the Medi-Cal program. It does not establish standards for services to any other members of Anthem or its affiliates. If a section of the manual applies only to a specific program, that program will be indicated. If there is no such indication, the information is applicable to all programs.

By accepting this manual, Anthem providers agree to use this manual solely for the purposes of referencing information regarding the provision of medical services to Medi-Cal members who have chosen Anthem as their health plan.

This manual does not obligate providers to provide services to members enrolled in any of these programs unless the provider is under contract with Anthem to provide services in one or more of these programs. Providers are only required to follow the standards in this manual that are applicable to the program in which the member is currently enrolled.

Updates and Changes

The provider manual, as part of your provider agreement and related addendums, may be updated at any time and is subject to change. In the event of an inconsistency between information contained in the manual and the Agreement between you or your facility and Anthem, the 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, fax communications and other mailings. In such cases, the most recently published information should supersede all previous information and be considered the current directive.

The 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, including, but not limited to, letters, bulletins, and newsletters.

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

Chapter 2: Quick Reference

Websites and Community Resources

A wide array of valuable tools, information and forms are available on the following websites:

- mss.anthem.com/CA
- providers.anthem.com/CA

Online Tools for Providers

Availity Essentials is a secure website for Anthem eligibility, benefits and claim status inquiry functionality. All participating providers must register for Availity Essentials to access these functions and additional value-added features and services.

Here are some of the other features and tools available on the Availity Essentials platform:

- Dispute a claim
- Submit medical attachments
- Remittance Inquiry
- Precertification Lookup Tool
- Clear Claims Connection
- Claim Status Listing
- Single or Batch Claim Submission
- Custom Learning Center
- Provider Online Reporting (Eligibility & Roster Reports
- Patient360

Use of the Availity Essentials platform will minimize time spent on the telephone with Customer Service and allow more time for you to spend with your patients. In fact, it may eliminate 80% of routine inquiries to Anthem.

Availity Essentials is available 24 hours a day, 7 days a week, except during scheduled maintenance and national holidays. Availity Essentials offers printer-friendly formats on all information screens.

Availity Essentials

To gain access to Availity Essentials:

- Go to Availity.com > **Register** > **Get Started** > Complete the online registration form.
- If you have questions about registering for the Availity Essentials platform, contact Availity Client Services at **800-282-4548**.

Patient360 on Availity Essentials

Patient360 is real-time dashboard that gives you a robust picture of a patient's health and treatment history and will help you facilitate care coordination. You can drill down to specific items in a patient's medical record to retrieve demographic information, care summaries, claims details, authorization details, and more.

With this level of detail at your fingertips, you will be able to:

- Spot utilization patterns.
- Avoid service duplication.
- Identify care gaps and trends
- Coordinate care more effectively.
- Reduce the number of communications needed between PCPs and case managers.

Patient360 is offered on the Availity Essentials platform. This online application lets you quickly retrieve detailed records about your Anthem patients. Patient360 replaces the Patient Care Summary that was previously accessed through *Eligibility and Benefits* on the Availity Essentials platform. It will also replace Member Medical History Plus (MMH Plus).

You must first be assigned the Patient360 role in Availity Essentials; administrators can make this assignment within the *Clinical Roles* options. Then navigate to Patient360 using one of the methods outlined on the following page.

Method 1

Select **Patient Registration** from the top menu bar in Availity Essentials:

1. Select **Eligibility and Benefits**.
2. Complete the required fields on the *Eligibility and Benefits* screen.
3. Select the **Patient360** link on the member's benefit screen.
4. Enter the member's information in the required fields.

Method 2

1. Select **Payer Spaces** from the top menu bar in Availity Essentials.
2. Select the **Anthem** tile.
3. Select **Patient360** located on Applications page.
4. Enter the member's information in the required fields.

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 use digital tools, unless otherwise prohibited by law or other legal requirements.

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

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

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

Digital functionality available through Availity Essentials include:

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

Additional digital applications available to providers and facilities include:

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

Anthem expects providers and facilities transacting any functions and processes above will use available digital and/or electronic self-service applications in lieu of manual channels (for example, paper, mail, fax, call, chat). 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.

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.

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.

Prior Authorization Submission, Attachment, Status, and Clinical Appeals

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

- EDI transaction: X12 278 – prior authorization and referral:
  - Anthem supports the industry standard X12 278 transaction for prior authorization submission and status inquiry as mandated per HIPAA.
- EDI transaction: X12 275 – patient information, including HL7 payload for authorization attachments:
  - Anthem supports the industry standard X12 275 transaction for electronic transmission of supporting authorization documentation including medical records via the HL7 payload.
- Availity Essentials:
  - The Availity Essentials multi-payer Authorization application facilitates prior authorization submission, authorization status inquiry, and the ability to review previously submitted authorizations. Provider desktop integration via B2B APIs:
    - Anthem has enabled real-time access to prior authorization APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

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
  - The Claims & Payments application enables providers and facilities to enter a claim directly into an online claim form and upload supporting documentation for a defined claim.
  - The 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 they are integrated.
- Provider desktop integration via B2B APIs:
  - Anthem has also enabled real-time access to Claim Status via APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity Client Services 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.
  - The Claim Status application enables providers and facilities to digitally submit supporting Claims documentation, including medical records, directly to the claim.
  - Digital Request for Additional Information (Digital RFAI) – The Medical Attachments application on Availity Essentials enables the transmission of digital notifications when additional documentation including medical records are needed to process a claim.

Electronic Remittance Advice and Electronic Claims Payment

Electronic Remittance Advice

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

Providers and facilities can register, enroll, and manage their ERA preference through Availity.com.

Printing and mailing remittances will automatically stop thirty (30) days after the ERA enrollment date.

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

To stop receiving ERAs for your claims, contact Availity Client Services at **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.

Provider Enrollment and Network Management

Provider Enrollment

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

Contract Changes

- Streamlined Contract Change Requests: Providers and facilities can easily submit certain requests for contract changes through Availity Essentials:
  - Amendments requests to add a network or line of business
  - Change of Ownership notice
  - Contract, line of business, or Network Termination requests
  - TIN Change
- **Real-Time Tracking**: Providers and facilities can track the status of their requests in the **My Dashboard** section of the Provider Enrollment and Network Management application.

My Roster

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

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

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

See the next section for more information about Provider Data Management.

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

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

Demographic Updates

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

While there are two options available, providers only need to use one or the other. The Availity Essentials PDM application option is available at no cost to providers, and the Symphony option is a premium service available for an additional cost if providers choose to sign up for it.

For provider and facilities using the roster upload option, additional resources are available:

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

Health Education and Cultural and Linguistic Needs

Health education classes and cultural and linguistic requests are available at no charge to Anthem members enrolled in Medi-Cal and are accessible upon self-referral or referral by Anthem network providers.

Providers can refer members to health education classes using the Referral form which can be accessed at providers.anthem.com/california-provider/resources/forms > **Patient Care drop down.**

Additional information on interpreter services is available on the Interpreter Services section of our Provider Training Academy at providers.anthem.com/california-provider/resources/provider-training-academy.

For after-hours telephone interpreter services, members can call the 24/7 NurseLine at **800-224-0336 (TTY 711)**.

Medical Appointment Standards

Healthcare providers must make appointments for members from the time of request as follows:

Type of appointment	Timeframe
Emergency examination	Immediate access 24 hours/7 days a week
Urgent (sick) examination	Within 48 hours of request if authorization is not required or within 96 hours of request if authorization is required or as clinically indicated (Urgent standards include weekends and holidays)
Routine primary care examination (nonurgent)	Within 10 business days of request
Non-urgent consults/specialty referrals	Within 15 business days of request
Non-urgent care with nonphysician mental health providers (where applicable)	Within 10 business days of request
Non-urgent follow-up care with non-physician mental health provider or substance use disorder provider	Within 10 business days of request
Non-urgent ancillary	Within 15 business days of request
Non-urgent dental providers	Within 36 business days of request
Dental Preventive Care Appointment	Within 40 business days of request
Initial health appointments for members 21 years of age and over	Within 120 days of enrollment
Preventive care visits	Within 14 days of request
Routine physicals	Within 30 days of request
Initial health appointments (under age 21)	
Children under the age of 18 months	Within 120 days of enrollment or within American Academy of Pediatrics (AAP) guidelines, whichever is less
Children aged 19 months to 20 years of age	Within 120 days of enrollment
Prenatal and postpartum visits	
First prenatal visit	Within 2 weeks of request
1st and 2nd trimester	Within 7 days of request
3rd trimester	Within 3 days of request

High-risk pregnancy	Within 3 days of identification
Postpartum	Between 7 and 84 days after delivery
Interpretation Services	
Providers must demonstrate their awareness that members are entitled to receive 24/7 interpretation services. This can be, but not limited to, provided by the member's health plan by calling **800-407-4627**.	

Unless a qualified health professional has determined and documented that a longer wait time will not have a detrimental impact on the health of the member.

Contact Information

The following resource grid is a consolidation of the most-used phone and fax numbers, websites and addresses found within the manual itself. We've also included other valuable contact information for you and your staff.

State of California

Health services programs handled by the state:

State services contacts	Phone/fax numbers	Other contact information
Automated Eligibility Verification System (AEVS)	**800-456-2387**	
California Children's Services (CCS)	Phone numbers are county -specific. Los Angeles County Phone: **800-288-4584** Fax: **855-481-6821**	Referrals: dhcs.ca.gov/services/california-childrens-services
Community-Based Adult Services (CBAS)	California Department of Aging: Within California: **916-419-7500** Outside California: **800-677-1116**	aging.ca.gov/Programs_and_Services/Community-Based_Adult_Services
Denti-Cal	**800-452-0507** 8 a.m.–5 p.m., Monday through Friday	dental.dhcs.ca.gov
Department of Health Care Services Medi-Cal Managed Care Ombudsman	**888-452-8609**	dhcs.ca.gov/services/mental-health-services-division-default/medi-cal-managed-care-and-mental-health-office-of-the-ombudsman
Department of Health Care Services Office of Family Planning	**800-942-1054**	dhcs.ca.gov/services/office-of-family-planning-officeoffamilyplanning
Department of Health Care Services / Medi-Cal Rx (Important Contact Information)	Medi-Cal Rx Customer Service Center: **800-977-2273** available 24 hours a day, 7 days a week, 365 days per year Provider Prior Authorization fax: **800-869-4325** Provider Paper Claims fax:	medi-calrx.dhcs.ca.gov

State services contacts	Phone/fax numbers	Other contact information
	866-391-6726 Medi-Cal Rx-specific FWA hotline: **800-375-1251** (**TTY 711**) email: SIU@magellanhealth.com	
Department of Public Health Childhood Lead Poisoning Prevention Branch	**510-620-5600**	cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/prov.aspx
Department of Social Services Public Inquiry and Response Unit	**800-952-5253**	
Department of Managed Health Care	**877-525-1295**	dmhc.ca.gov
Indian Health Services	**916-930-3927**	ihs.gov/California
Medi-Cal Telephone Service Center	**800-541-5555**	
Medi-Cal Rx contact information	**800-977-2273**	medi-calrx.dhcs.ca.gov
Medi-Cal Rx Fraud, Waste and Abuse		Allegations must be reported to the Program Integrity/Special Investigations Unit (PI/SIU) within one calendar day. FWA related to Medi-Cal Rx should be reported via the central SIU email or via the Medi-Cal Rx specific FWA hotline number at **800-375-1251** (TTY **711**) Email Magellan SIU: SIU@magellanhealth.com
Non-Medi-Cal Rx-specific FWA or alternative methods of reporting	Magellan SIU Pharmacy FWA hotline: **800-349-2919** Main Magellan SIU hotline: **800-755-0850** Magellan Rx Compliance hotline: **800-915-2108**	Forms sent via interoffice mail Fax to PI/SIU **888-656-2407** Email Magellan Rx Management Compliance Department: MRxCompliance@magellanhealth.com Referrals sent to PI/SIU physical address: PI/SIU, Medi-Cal Rx 11000 White Rock Road Rancho Cordova, CA 95670 Referrals sent to central SIU physical address: SIU, Magellan Health, Inc. P.O. Box 1746 Maryland Heights, MO 63043

Anthem

Contact information related to Medi-Cal programs:

Contact	Outside L.A. County	Inside L.A. County	Hours of operation (PT)	Address, email, fax and/or website
24/7 NurseLine	**800-224-0336** **800-368-4424 (TTY 711)**		24 hours a day, 7 days a week	Can be used for after-hours member eligibility verification and after-hours requests for interpreter services
Availity Essentials	**800-282-4548**		5 a.m.–5 p.m., Monday-Friday	Availity.com Log in or follow instructions to create an account.
Case Management	**888-334-0870**		8 a.m.–5 p.m., Monday–Friday	Fax: **866-333-4827**
Claims: Follow-up	Anthem P.O. Box 60007 Los Angeles, CA 90060-0007			
Claims: Overpayment Recovery	Overpayment Recovery Anthem P. O. Box 92420 Cleveland, OH 44135		Overnight packages: Overpayment Recovery Anthem Lockbox 92420 4100 West 150th St. Cleveland, OH 44135	
Claims: EDI	Availity Client Services at **800-AVAILITY (800-282-4548)**		5 a.m.–5 p.m. Monday–Friday	anthem.com/provider/edi
Claims: Paper	Anthem, P.O. Box 60007, Los Angeles, CA 90060-0007			
Community-Based Adult Services (CBAS)	**855-871-4899**		8 a.m.–5 p.m., Monday–Friday	Fax: **855-336-4042** (LA County) Fax: **855-336-4041** (All other counties)
Community Supports	**855-871-4899**		8 a.m.–5 p.m., Monday–Friday	Community Supports CalAIM@Anthem.com Fax: **877-734-1857**
Enhanced Care Management	**833-884-0385**		8 a.m.–5 p.m., Monday–Friday	Enhanced Care Management CalAIM@Anthem.com Fax: **877-734-1854**
Customer Care Center	**800-407-4627 (TTY 711)**	**888-285-7801 (TTY 711)**	7 a.m.–7 p.m., Monday–Friday	For after-hours services, please call 24/7 NurseLine (see below).
Fraud and Abuse: Medi-Cal	**888-231-5044** (Blue Cross of California Fraud Hotline)		7 a.m.–7 p.m., Monday–Friday	Fax: **866-454-3990**
Grievances & Appeals	Fax: **866-387-2968**	Physician/Provider Grievance form		Grievance & Appeals Department: Anthem P.O. Box 60007 Los Angeles, CA 90060-0007 Fax: **866-387-2968**

Contact	Outside L.A. County	Inside L.A. County	Hours of operation (PT)	Address, email, fax and/or website
Health Care Options	**800-430-4263**		8 a.m.–5 p.m., Monday–Friday	
Hearing Impaired Services: California Relay Service	**711** or Voice to TTY, English: **800-735-2922** Spanish: **800-855-3000** TTY to voice, English: **800-735-2929** Spanish: **800-855-3000**		24 hours a day, 7 days a week	For additional information, visit the California Relay Service webpage at ddtp.cpuc.ca.gov
Interpreter Services	Medi-Cal: **800-407-4627** After hours, use 24/7 NurseLine: **800-224-0336** **800-368-4424 (TTY 711)**		8 a.m.–5 p.m., Monday–Friday	Face-to-face interpreters can be requested via email at: ssp.interpret@Anthem.com
Long-Term Services and Supports	**855-871-4899**		8 a.m.–5 p.m., Monday–Friday	Fax: **844-285-1167** (Northern CA); **877-279-2482** (Southern CA)
Medi-Cal for Families Information Line	**800-880-5305**		8 a.m.–8 p.m., Monday–Friday 8 a.m.–5 p.m., Saturday	
Member Eligibility: Anthem	Interactive Voice Response (IVR) **800-407-4627**	IVR: **888-285-7801**	24 hours a day, 7 days a week	
Member Eligibility: State of California	Automated Eligibility Voice System (AEVS): **800-456-2387**		24 hours a day, 7 days a week	mcweb.apps.prd.cammis.medi-cal.ca.gov
Network Relations Department				anthem.com/provider/contact-us
Pharmacy Prior Authorization Center As of January 1, 2022, pharmacy benefits are handled by Medi-Cal Rx	**800-977-2273** (Medi-Cal Rx Customer Service Call Center)	**800-977-2273** (Medi-Cal Rx Customer Service Call Center)	7 a.m.–7 p.m., Monday–Friday	Fax: **800-869-4325** (Medi-Cal Rx Fax #) or go to medi-calrx.dhcs.ca.gov
Provider Relations (Behavioral Health Providers)				providers.anthem.com/california-provider/contact-us/email
Secure email: eBusiness Help Desk	**866-755-2680**		5 a.m.–5 p.m., Monday–Friday	
TTY	**711**		8:30 a.m.–7 p.m., Monday–Friday	
Utilization Management: Medi-Cal	**888-831-2246**		8 a.m.–5 p.m., Monday–Friday	Physical Health fax: **800-754-4708**

Contact	Outside L.A. County	Inside L.A. County	Hours of operation (PT)	Address, email, fax and/or website
				Behavioral Health: **855-473-7902** All Requests for Prior Authorizations should be submitted via Availity.com.
Utilization Management (except LTC and CBAS): Delegated Groups to Perform UM	**888-831-2246**		8 a.m.–5 p.m., Monday–Friday	Fax: **888-232-0708**
Vision Services: Vision Service Plan (VSP)	**800-615-1883**		5 a.m.–8 p.m., Monday–Friday 6 a.m.–5 p.m., Saturday	vsp.com

Covered Services Grid

The following table lists benefits covered by the Medi-Cal Managed Care program. This is not an all-inclusive list of benefits. For pharmacy benefit information, see Chapter 6: Pharmacy. For questions about services not listed, please contact the Customer Care Center or Provider Relations for assistance. Services received from an out-of-network provider without an authorization or referral are not covered, except in the case of abortion services or medical emergencies.

Benefits and services	Covered by Anthem * Prior authorization (PA) required		Covered by DHCS Fee-for-Service (FFS) or other state/county agencies
Abortion		Covered	
Acupuncture		Covered	
Allergy testing: • Antigen		Covered	
Ambulance services: • Air ambulance • Dry runs • Ground ambulance • Nonemergent transport from home to doctor's office, dialysis, or physical therapy	Yes	Covered	
Amniocentesis		Covered	
Anesthetics (administration)		Covered	
Artificial insemination		Not covered	
Audiology services		Covered	
Behavioral health • Mental health evaluation and treatment, including individual, group and family psychotherapy • Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition • Outpatient services for purposes of monitoring drug therapy • Psychiatric consultation • Outpatient laboratory, drugs, supplies, and supplements (Including physician administered drugs administered by a healthcare professional in a clinic, physician's office, or outpatient setting		Professional services covered; may require preauthorization	Inpatient and specialty mental health services outpatient services administered by the DHCS FFS Program, specifically County Mental Health Departments

Benefits and services	Covered by Anthem * Prior authorization (PA) required		Covered by DHCS Fee-for-Service (FFS) or other state/county agencies
through the medical benefit, to assess and treat mental health conditions) • Applied behavioral analysis (ABA) for members under 21 years of age			
Biofeedback		Not covered	
Blood and blood products		Covered	
Cancer screening		Covered	
Cataract spectacles and lenses	Yes	Covered when medically necessary	
Chemical dependency rehabilitation			Administered by the DHCS FFS Program, specifically County Mental Health Departments
Chemotherapy drugs		Covered	If under 21 years of age, services covered by California Children's Services
Circumcision		Not covered unless medically necessary	
Colostomy supplies • Inpatient facility • Outpatient dispensing • In conjunction with home health		Covered	
Community-based adult services		Covered	
Community Health Worker		Covered	
Community Supports	*Yes	Covered: dependent on County *Prior authorization is required for most Community Supports	
Dental services (medical) • Accidental injury — inpatient facility or emergency room • Professional component (anesthesia)		Medically necessary services administered in connection with dental services that are not performed by dental providers.	
Dental services — preventive and restorative		Not covered	Covered by DHCS dental programs, Denti-Cal or dental managed care (county specific)

Benefits and services	Covered by Anthem * Prior authorization (PA) required		Covered by DHCS Fee-for-Service (FFS) or other state/county agencies
Detoxification (acute phase)		Not covered	Administered by the DHCS FFS Program, specifically County Mental Health Departments
Diabetic services		Covered for members 21 years of age and older	If under 21 years of age, services covered by California Children's Services
Diagnostic X-ray • Must use contracted radiology provider		Covered: • Prior authorization required for selected CT/MRI/MRA/PET/SPECT	
Dialysis		Covered for members 21 years of age and older	If under 21 years of age, services covered by California Children's Services
Directly observed therapy (DOT) for the treatment of tuberculosis		Not covered	Covered by DHCS FFS Program
Doula		Covered	
Durable medical equipment	Yes	Covered except the below: • Items used only for comfort or hygiene • Items used only for exercise • Air conditioners, filters, or purifiers • Spas, swimming pools	
Dyadic Services and Family Therapy Benefit		Available to families as long as the child (member under age 21) is enrolled in Medi-Cal	
Medi-Cal for Kids & Teens (EPSDT Services): • Applies to members under 21 years of age. • Services based on the AAP/Bright Futures periodicity schedule and USPSTF "A" and "B" recommendations. • Immunizations based on (ACIP) guidelines.		Preventive care services are covered including, but not limited to: • Health screenings • Physical exams • Developmental screenings • ACEs screenings • Hearing screenings • Vision screenings • Dental screenings • Vaccines • Health education	

Benefits and services	Covered by Anthem * Prior authorization (PA) required		Covered by DHCS Fee-for-Service (FFS) or other state/county agencies
		• Anemia lead, dyslipidemia screening and blood tests • TB, STI, and HIV screenings • Depression screening: maternal and adolescent	
Emergency room • In and outside of California • Outpatient facility services • Professional		Covered	
End of Life Services		Not Covered	Covered
Endoscopic studies		Covered	
Enhanced Care Management		Covered	
Experimental procedures		Not covered	Not covered
Family planning services and supplies (in or out of network)		Covered: • Birth control • Education and counseling • Pregnancy tests • Sexually transmitted disease screening • Sterilization Not covered: • Sterilization reversal • Hysterectomy for sterilization • Fertility treatments	
Fetal monitoring		Covered	
Genetic testing			Covered; administered by the State Genetic Disease Branch
Health education		Covered	
Hearing aids		Covered	
Hemodialysis chronic renal failure		Covered	
Hepatitis B vaccine/gamma globulin		Covered	
Home healthcare services	Yes	Covered	
Hospice	Yes	Covered	

Benefits and services	Covered by Anthem * Prior authorization (PA) required		Covered by DHCS Fee-for-Service (FFS) or other state/county agencies
Hospital based physicians (in lieu of acute inpatient or SNF)		Covered	
Hospitalization • Inpatient services • Outpatient services • Intensive care services		Covered • Private room covered only if medically necessary	
Immunization administration • Pediatric vaccines • Adult vaccines • Obstetrical vaccines		Pediatric: Covered under Vaccines For Children (VFC) Adult: Covered according to ACIP recommendations Obstetrical: Covered according to ACIP recommendations	Covered: Medi-Cal Rx
Infant apnea monitor (outpatient)	Yes	Covered	
Infertility diagnosis and treatment		Not covered	
Injectable medications (outpatient and self-administered)		Covered: most office injections	Covered by DHCS Medi-Cal Rx
Inpatient alcohol and drug use			Administered by the DHCS FFS Program, specifically County Mental Health Departments
Interpreter services		Covered	
Lab and pathology services		Covered	
Lithotripsy	Yes	Covered	
Major organ transplants	Covered for members 21 years of age and older	If under 21 years of age, services covered by California Children's Services	
Mammography		Covered	
Mastectomy		Covered	
Maternity care • Pre- and post-natal care • Nurse/midwife services • Childbirth and cesarean section • Newborn exam		Covered	Alpha fetoprotein (AFP) screening covered by the DHCS FFS Program
Nutritionist/dietician	Yes	Covered	
Obstetrical/gynecological services		Covered	

Benefits and services	Covered by Anthem * Prior authorization (PA) required		Covered by DHCS Fee-for-Service (FFS) or other state/county agencies
• Inpatient facility fees • Inpatient professional fees • Outpatient professional fee • Professional fee • Obstetrical CPSP services • Vaccines per ACIP recommendations			
Office visit supplies including splints, casts, bandages, and dressings		Covered	
Ophthalmology services		Covered	
Vision care • Routine eye exam • Eyeglasses (frame and lenses)		Covered once every 24 months.	
Physical, occupational and speech therapy • Inpatient or SNF • Outpatient • Professional	Yes (For PT only)	Covered	
Physician office visits		Covered	
Podiatry services		Covered if: • Provided by a physician • Outpatient setting • Clinic	
Preadmission testing		Covered	
Prosthetics and orthotics (including artificial limbs and eyes)	Yes	Covered	
Psychology services (psychological testing when clinically indicated to evaluate a mental health condition)	Yes	Covered	
Radiation therapy		Covered	
Radiology services • Inpatient facility component • Outpatient facility component • Professional component	Yes (for some OP services)	Covered	

Benefits and services	Covered by Anthem * Prior authorization (PA) required		Covered by DHCS Fee-for-Service (FFS) or other state/county agencies
Reconstructive surgery (not cosmetic)	Yes	Covered	
Rehabilitation services	Yes	Covered	
Routine physical examinations		Covered except when required by job, school, camp, or sports program	
Skilled nursing facility (SNF) • Long-term care under LTSS	Yes	Covered	
Specialist consultations		Covered	
TMJ treatment	Yes	Covered	
Transcranial magnetic stimulation (TMS)	Yes	Covered* for 90867, 90868, 90869	
Transfusions (blood and blood products)		Covered	
Transgender services		Covered	
Urgent care center		Covered	
Well Visits – Adults • Applies to adult members		Preventive care services are covered including: • Health screenings • Physical exams • Dental screenings • Testing as recommended by the USPSTF • Vaccines per ACIP recommendations • Health education	

Chapter 3: Member Eligibility

Verifying Eligibility

Anthem providers are required to verify a person's eligibility and identity before services are rendered at each visit. Providers must ask to see two separate ID cards to verify state Medi-Cal and Anthem eligibility.

Because eligibility can change, eligibility should be verified at every visit. Claims submitted for services rendered to a member that is not eligible are not reimbursable.

Prior to delivering services to members, providers must review the Medi-Cal eligibility record for the presence of Other Health Coverage (OHC). If the requested service is covered by the OHC, providers are to instruct the member to seek the service from the OHC carrier.

Anthem will not process a claim for a member whose Eligibility Record indicates OHC (other than a code F) unless the provider presents proof that all sources of payment have been exhausted or the provided services meet the requirement for billing Medi-Cal directly.

As stated in Title 42 U.S. Code Section 1396a(a)(25)(D), regardless of presence of OHC, providers should not refuse a covered Medi-Cal service to a Medi-Cal member.

Beneficiary Identification Card

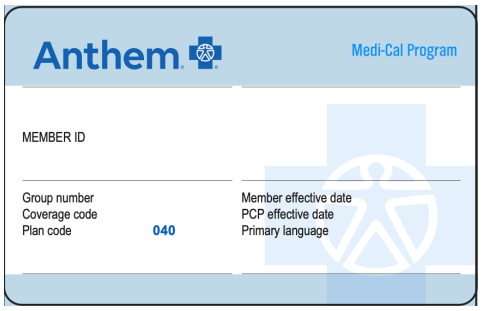
The state of California Department of Health Care Services (DHCS) issues the Beneficiary Identification Card (BIC) after approving the person's Medi-Cal eligibility. The BIC is composed of a nine-character Client Identification Number (CIN), a check digit and a four-digit date that matches the date of issue. Effective September 12, 2016, DHCS implemented a new BIC card design. New Medi-Cal ID cards will not be replaced all at once. Providers should accept both BIC designs.

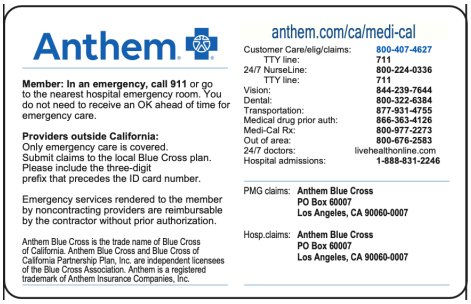
Old BIC Card New BIC Card

Anthem Member ID Cards

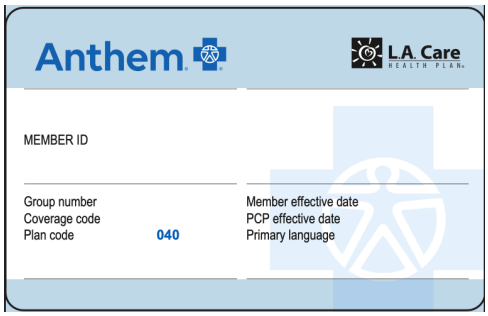
Anthem provides members an ID card with plan and provider information on the front and back (sample below).

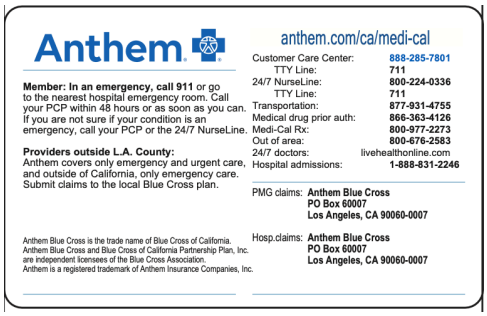
Non-Los Angeles County Members





Los Angeles County Members





Note: Los Angeles County members will have a slightly different looking card than non-Los Angeles County members.

Anthem electronically updates member eligibility each day following notification from the DHCS.

individual Eligibility

To verify managed care Medi-Cal member eligibility, choose one of the following four options:

A. Swipe the BIC in a POS device.
B. Use the Automatic Eligibility Verification System (AEVS) by calling AEVS at **800-456-2387**
C. Log on to the Medi-Cal website at:
   - mcweb.apps.prd.cammis.medi-cal.ca.gov
   - Enter your user ID and password.
   - Select **Submit**, which will take you to the *Real Time Internet Eligibility* page.
   - Enter member information including subscriber ID, birth date, issue date and service date.
D. Log on to the secure Availity Essentials platform at
   - Availity.com

From top navigation bar:

- Select **Patient Registration**
- Select **Eligibility and Benefits Inquiry**
- Payer: **Anthem-CA**
- Enter your **National Provider Identifier** (NPI)
- Complete **Patient Information**

Note: Items with an asterisk (*) are required.

Required information on Availity Essentials includes:

- Member ID and the alpha prefix
- Patient Date of Birth or Patient First and Last Name
- Date of Service (defaults to current date)
- Selection of defined HIPAA service types
- An active member will show a term date of 12/31/9999

Note: To be HIPAA Version 5010 compliant, providers are no longer able to conduct a name search.

Eligibility Rosters and Capitation Reports
Log in to the Availity Essentials platform:

- Select **Payer Spaces** > **Provider Online Reporting** once your Availity Essentials Administrator has granted you access to the Provider Online Reporting role. The following reports can be obtained:
  - State Sponsored Eligibility Reports – Professional Medical
  - State Sponsored Capitation Reports – Professional Medical

Enrollment/Disenrollment

- Medi-Cal Enrollment (Health Care Options): **800-430-4263** (TTY **800-430-7077** or **711**)
  Hours of operation: Monday to Friday, 8 a.m. to 6 p.m. except holidays.

The Medi-Cal managed care enrollment process is managed by Health Care Options (HCO).

Individuals and families whose applications are approved for Medi-Cal receive a pre-enrollment packet that includes a Medi-Cal Managed Care Enrollment form and the plan's provider directory.

Members must return the signed enrollment form within 45 days including selection of a healthcare plan and a primary care provider (PCP). If the member does not choose a healthcare plan within the given time frame, the state assigns the member to a Medi-Cal plan.

To learn more about the enrollment process or to obtain the most current forms and information, visit healthcareoptions.dhcs.ca.gov > Enroll

Additional information is available via the following resources the California DHCS Medi-Cal website at medi-cal.ca.gov.

State Agency-initiated Member Disenrollment

The DHCS informs Anthem of membership changes by sending daily and monthly enrollment reports. These reports contain all active membership data and incremental changes to eligibility records.

Anthem disenrolls members who are not listed on the monthly full replacement file effective as of the designated disenrollment date. Reasons for disenrollment may include:

- Change in eligibility status
- County or residence changes
- Healthcare plan mergers or reorganizations
- Incarceration
- Loss of benefits
- Permanent change of residence out of service area
- Voluntary disenrollment

Member-initiated PCP Changes

Members have the right to change their PCP monthly or more frequently under certain conditions. When beneficiaries enroll in a Medi-Cal managed care program, they can choose a PCP when selecting their managed care plan. If a beneficiary does not select a PCP when selecting a managed care plan, Anthem will select a PCP for the member.

Members are instructed to call the Medi-Cal Customer Care Center below to request an alternate PCP:

Location	Customer Care Center Phone
L.A. County	**888-285-7801** Monday to Friday, 7 a.m. to 7 p.m.
Outside L.A. County	**800-407-4627** Monday to Friday, 7 a.m. to 7 p.m.
TTY	**888-757-6034** (**TTY 711**)

Anthem accommodates member requests for PCP changes whenever possible. Our staff will work with the member to make the new PCP 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 Customer Care Center (CCC) representative checks the availability of the member's choice. If the member can be assigned to the selected PCP, the CCC representative will do so.
- If the PCP is not available, the CCC representative will assist the member in finding an available PCP.
- If the requested PCP is not available and the member indicates there is an established relationship with the PCP, the CCC will contact the PCP to confirm the member has an established relationship and whether the PCP will accept the assignment.
- If the member advises the CCC that they are hospitalized, the CCC will advise the member to call us upon discharge so that we can assist them with their PCP change.
- Anthem notifies PCPs of members' transfers to a new PCP through monthly enrollment reports. PCPs can access these reports by going to our secure Availity Essentials website at essentials.availity.com.

- The effective date of a PCP transfer will be the first day of the following month. Anthem may assign a member retroactively on a case-by-case basis.

Member Transfers to Other Plans

Members can voluntarily disenroll and choose another healthcare plan at any time, subject to a restricted disenrollment period.

Approved disenrollments become effective no later than the first day of the second month following the month in which the member files the request. Disenrollment may result in either of the following:

- Enrollment with another healthcare plan
- Return to traditional or original fee-for-service Medi-Cal for continuity of care if the member's benefits fall into a voluntary aid code

If a member asks a provider how to disenroll from Anthem, the provider should direct the member to call the Customer Care Center in their area:

- Medi-Cal Health Care Options: **800-430-4263 (TTY 800-430-7077)**

The member must complete a Request for Disenrollment form and mail it to:

CA Department of Health Care Services
Health Care Options
P.O. Box 989009
West Sacramento, CA 95798-9850

Member Nondiscrimination

does not engage in, aid, or perpetuate discrimination against any person by providing significant assistance to any entity or person that discriminates based on race, color or national origin in providing aid, benefits or services to beneficiaries. Anthem does not use 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) by phone, in writing or electronically:

- Electronically: Through the OCR complaint portal at ocrportal.hhs.gov/ocr.
- By mail to: Fill out a complaint form or send a letter 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 800-537-7697** or **711** to use the California Relay Service if you cannot speak or hear well)

Complaint forms are available at hhs.gov/ocr/complaints.

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:

Contact Type	Outside L.A. County	Inside L.A. County
Mailing address	Attn: Grievance Coordinator Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007	Attn: Grievance Coordinator Anthem Blue Cross P.O. Box 9054 Oxnard, CA 93031-9054
Phone	Medi-Cal Customer Care Center **800-407-4627** (**TTY 711**)	Medi-Cal Customer Care Center **888-285-7801** (**TTY 711**)

Equal Program Access on the Basis of Gender

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

Chapter 4: General Benefits

Benefit Programs and Populations

Medi-Cal Managed Care

Medi-Cal Managed Care (Medi-Cal) is a complex network of public and private healthcare providers who serve California's most vulnerable citizens: low-income California residents who lack health insurance.

As part of the CalAIM initiative, the final phase of Mandatory Managed Care Enrollment became effective January 1, 2023. The Department of Health Care Services (DHCS) will be transitioning Medi-Cal beneficiaries who are currently excluded from or voluntary for managed care plan (MCP) enrollment into a MCP as they will no longer be permitted to remain in the fee-for service delivery system. This will include all full- and partial-benefit dual beneficiaries, including non-dual beneficiaries residing in a long-term care (LTC) facility. The goal is to align managed care enrollment practices that currently vary by aid code, population, and geographic location.

Medi-Cal pinpoints 165 categories of eligibility but generally covers the following populations:

- Individuals in special treatment programs (including tuberculosis and dialysis)
- Individuals with refugee status
- Low-income children and their parents
- Low-income pregnant women
- Qualified low-income Medicare recipients
- Seniors and persons with disabilities

Anthem provides Medi-Cal services (Medicaid) for the California Department of Health Care Services and the Department of Public Health in the following counties:

- Alpine
- Amador
- Calaveras
- El Dorado
- Fresno
- Inyo
- Kings
- Kern
- Los Angeles (in partnership with L.A. Care Health Plan)
- Madera
- Mono
- Sacramento
- San Francisco
- Santa Clara
- Tulare
- Tuolumne

A covered services grid can be found in Chapter 2: Quick Reference. Anthem members enrolled in Medi-Cal Managed Care do not have deductibles or copays.

State and County-sponsored Programs

To ensure continuity and coordination of care for our members, Anthem enters into agreements with locally based state and county public health services and programs. Providers are responsible for notifying Utilization Management when a referral is made to any of the agencies or programs listed below.

This notification ensures that case manager nurses and social workers can follow up with members to coordinate care. It also ensures that members receive all necessary services while keeping the provider informed.

- Behavioral Health
- California Children's Services (CCS)
- California Early Start
- Directly Observed Therapy for Tuberculosis (DOT)
- End of Life Services (Contact the Medi-Cal and Provider Helpline at **800-541-5555**. Outside of CA, call **916-636-1980**)
- Family Planning Services
- HIV Counseling and Testing
- Immunization Services
- Women, Infants and Children (WIC)
- Waiver Programs
- Targeted Case Management
- Mental health
- Alcohol and substance use disorder treatment services
- Sexually transmitted diseases
- Behavioral Health and Substance Use Disorder

Behavioral Health and Substance Use Disorders

Outpatient (Medi-Cal)

Behavioral healthcare services are covered for the treatment of a behavioral health condition. The conditions covered include:

- Treatment for members who have experienced mild to moderate behavioral, cognitive, or emotional impairment related to a behavioral health diagnosis as identified by DSM-V with traditional outpatient therapy and psychiatry services.

More specifically, Anthem will arrange for members to receive the following Non-Specialty Mental Health Services (NSMHS):

- Mental health evaluation and treatment, including individual, group and family psychotherapy.[1]
- Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
- Outpatient services for purposes of monitoring drug therapy.
- Psychiatric consultation.
- Outpatient laboratory, drugs, supplies, and supplements.[2]

In addition to the above requirements, Anthem will provide psychotherapy to members under the age of 21 with specified risk factors or with persistent mental health symptoms in the absence of a mental health disorder.

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1 Details regarding NSMHS psychiatric and psychological services, including psychotherapy coverage, Current Procedural Terminology (CPT) codes that are covered, and information regarding eligible provider types can be found in the Medi-Cal Provider Manual, Non-Specialty Mental Health Services: Psychiatric and Psychological Services (https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/D84845A9-9DA6-434D-8B97-00CD24F101E7/nonspecmental.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO).

2 This does not include medications covered under the Medi-Cal Rx Contract Drug List, which can be accessed at: medi-calrx.dhcs.ca.gov/home/cdl.

Further, Anthem will cover up to 20 individual and/or group counseling sessions for pregnant and postpartum individuals with specified risk factors for perinatal depression when sessions are delivered during the prenatal period and/or during the 12 months following childbirth.

Anthem covers outpatient laboratory tests, drugs, supplies, and supplements prescribed by mental health providers in their network and PCPs, including physician administered drugs administered by a healthcare professional in a clinic, physician's office, or outpatient setting through the medical benefit, to assess and treat mental health conditions. Anthem may require that NSMHS for adults are provided through the MCP's provider network, subject to a medical necessity determination. The laboratory testing may include tests to determine a baseline assessment before prescribing psychiatric medications or to monitor side effects from psychiatric medications. Supplies may include laboratory supplies.

Lastly, Anthem covers and reimburses for emergency room professional services as described in Section 53855 of Title 22 of the California Code of Regulations (CCR). This includes all professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services medically necessary to stabilize the member. Emergency services include facility and professional services and facility charges claimed by emergency departments.

This applies to the following populations:

- Members who are 21 years of age and older with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders;
- Members who are under the age of 21, to the extent they are eligible for services through the Medi-Cal for Kids & Teens (EPSDT Services) benefit, regardless of the level of distress or impairment, or the presence of a diagnosis; and
- Members of any age with potential mental health disorders not yet diagnosed.

Further, Anthem will cover clinically appropriate non-specialty mental health services (NSMHS) for the above populations even when:

A. Services are provided prior to determination of a diagnosis, during the assessment period, or prior to a determination of whether NSMHS or Specialty Mental Health Services (SMHS) access criteria are met. Anthem will cover NSMHS delivered by providers during the assessment process, as well not deny or disallow reimbursement if the assessment concludes the member does not meet the criteria for NSMHS or SMHS.
B. Services are not included in an individual treatment plan. Anthem will reimburse NSMHS whether or not they are indicated in the member's treatment plan.
C. The member has a co-occurring mental health condition and substance use disorder (SUD). Anthem will cover NSMHS delivered by providers whether or not the member has a co-occurring SUD. Also, Anthem will not deny or disallow reimbursement for NSMHS for a member who meets NSMHS criteria based on possessing a co-occurring SUD, as long as all other Medi-Cal and service requirements are met. Likewise, SUD services, such as alcohol and drug screening, assessment, brief interventions, referral to treatment and Medication Assisted Treatment (MAT), are covered whether or the member has a co-occurring mental health illness.

D. NSMHS and SMHS services are provided concurrently if those services are coordinated and not duplicated. Anthem will not deny or disallow reimbursement for NSMHS when a member is simultaneously receiving clinically appropriate SMHS, if the services have been coordinated and are not duplicative. Further, the concurrent services, for adults and children under 21 years of age, must be coordinated between Anthem and Mental Health Plans (MHPs) to ensure member choice. This involves coordination between Anthem and MHPs to facilitate care transitions and referrals, ensuring the referral loop is closed, with the members involvement in the decision-making process.

Note: The treatment of Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) remains the primary responsibility of the local county mental health department for members in need of higher level of care services (inpatient, partial hospitalization, intensive outpatient) Both providers and members should continue to contact their county directly for support with Specialty Mental Health Services (SMHS). SMHS are managed by the Counties and these MHPs are required to provide or arrange for the provision of medically necessary SMHS for members in their counties who meet access criteria for SMHS as described in Behavioral Health Information Notice (BHIN 21-073).

- **(800) 318-8212** (Alpine)
- **(888) 310-6555** (Amador)
- **(800) 499-3030** (Calaveras)
- **(800) 929-1955** (El Dorado)
- **(800) 654-3937** (Fresno)
- **(800) 841-5011** (Inyo)
- **(800) 991-5272** (Kern)
- **(800) 655-2553** (Kings)
- **(800) 854-7771** (Los Angeles)
- **(888) 275-9779** (Madera)
- **(800) 687-1101** (Mono)
- **(888) 881-4881** (Sacramento)
- **(888) 246-3333** (San Francisco)
- **(800) 704-0900** (Santa Clara)
- **(800) 320-1616** (Tulare)
- **(800) 630-1130** (Tuolumne)

For more County Mental Health Department information, visit dhcs.ca.gov/individuals/county-mental-health-plan-information.

At Anthem, our behavioral healthcare benefit is fully integrated with the rest of our healthcare programs. The provider roles include:

- Ongoing communication and coordination with physical health and other providers
- Ongoing coordination with Anthem Care Management, for any member concurrently enrolled in Anthem Care Management.
- Encouraging members to consent to the sharing of behavioral health treatment information
- Coordination with treating providers when members are hospitalized
- Coordination with the County Mental Health Plan (CMHP) and County Alcohol and other Drug Programs (AOD) when members enter higher levels of care, specifically in need of SMHS.

Minor Consent

Effective July 1, 2024, without consent from a parent or legal guardian, minors 12 years of age or older may consent to non-specialty outpatient mental health treatment or counseling if, in the opinion of the attending professional person, the minor is mature enough to participate intelligently in the outpatient

services. The professional person must use their clinical judgment and expertise to make a determination regarding the minor's maturity to participate intelligently in these services.

The providers, subcontractors, and downstream subcontractors must ensure safeguards are in place to suppress confidential information and prevent appointment notifications, Notice of Adverse Benefit Determination documents, and any other communication that would violate the minor's confidentiality from being inappropriately delivered to the minor's parent or guardian.

Following consultation with the minor, the professional person must note their determination regarding the appropriateness of involvement of the parent or guardian in the member record, stating either:

- whether and when the person attempted to contact the minor's parent or guardian, and whether the attempt to contact was successful; or
- the reason why, in the professional person's opinion, it would be inappropriate to contact the minor's parent or guardian.

Children's Benefits (under age 21)

California Children's Services

California Children's Services (CCS) is a state program that treats children under 21 years of age with certain health conditions, diseases, or chronic health conditions and who meet the CCS program rules. If this health plan or your PCP believes a child has a CCS condition, they will be referred to the CCS program.

CCS program staff will decide if the child is eligible for CCS services. If the child can get these types of care, CCS providers will treat them for the CCS condition. The health plan will continue to cover the services that are not related to the CCS condition such as physicals, vaccines, and well-child checkups.

Anthem does not cover care given by the CCS program. For CCS to cover these problems, CCS must approve the provider, services, and equipment. The state (not Anthem) pays for CCS services.
CCS does not cover all problems. CCS covers most problems that physically disable or that need to be treated with medicines, surgery, or rehabilitation (rehab).

CCS covers children with problems such as:

- Cancers
- Tumors
- Hemophilia
- Diabetes
- Liver disease
- Cataracts
- Spina bifida
- AIDS
- Hearing loss
- Congenital heart disease
- Sickle cell anemia
- Thyroid problems
- Intestinal disease
- Cleft lip/palate
- Cerebral palsy
- Muscular dystrophy
- Seizures that are not controlled
- Rheumatoid arthritis
- Severe head, brain, or spinal cord injuries
- Severely crooked teeth
- Blood lead level of 20 micrograms per deciliter or above
- Serious chronic kidney problems

Approved CCS providers must submit claims on the appropriate form to the local CCS program according to the terms of their CCS agreement. CCS is the primary payer for CCS-eligible diagnosis; Anthem does not provide authorization for those conditions.

All providers, both in- and out-of-network, are obligated to follow CCS guidelines including the following:

- Refer CCS-eligible or potentially eligible conditions to CCS and Anthem within 24 hours or the next business day.
- Use CCS network physicians and hospitals. Non-CCS-paneled hospitals must contact CCS immediately for authorization of inpatient members who are not stable for transfer to a CCS-paneled hospital.

Anthem will not reimburse claims for CCS-eligible conditions denied by CCS for noncompliance with CCS program requirements. In addition, providers may not seek additional payment or compensation from members for any of the following:

- CCS-covered services
- CCS-denied claims due to failure to submit the application within CCS time frames
- CCS-denied claims due to failure to use CCS network physicians or hospitals

Anthem will reimburse for all healthcare services unrelated to the CCS-covered condition. We do not reimburse for services related to a potentially medically eligible condition or for care that is related to a condition that has been qualified by the local CCS program.

Medi-Cal for Kids and Teens

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for members under the age of 21 years is referred to as Medi-Cal for Kids & Teens in California. The program includes the Bright Futures/American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care recommendations highlighted in the most recent Periodicity Schedule. The schedule describes preventive services due at specific ages from infancy through adolescence.

Screening services include the following:

- Comprehensive health and developmental history
- Comprehensive, unclothed physical exam, including nutritional, height/weight, and Body Mass Index (BMI) assessments
- Behavioral health screenings, including screening for depression and tobacco, alcohol, and drug use.
- Developmental screening for physical and mental health using standardized screening tools
- Age-appropriate immunizations based on the AAP Periodicity Schedule and Advisory Committee on Immunization Practices (ACIP) recommendations
- Age-appropriate lab tests, including blood lead screening tests
- Oral health screening and referral to dentist- beginning at age 1 or eruption of first tooth
- Age-appropriate vision and hearing screenings
- Health education and anticipatory guidance for child and caregiver

For members under the age of 21 years, Anthem covers a more robust range of Medically Necessary services than is provided for adult members. Services for members under 21 years are considered medically necessary when the services are determined to correct or ameliorate defects and physical and mental illnesses. A service does not need to cure a condition. Services that maintain or improve a child's current health condition or those that can prevent adverse health outcomes are also covered because they ameliorate a condition. Maintenance services are defined as services that maintain or support rather than those that cure or improve health problems. The term "ameliorate" refers to making a condition more tolerable or better."

Medical Necessity decisions are individualized without consideration of flat or hard limits based on monetary caps or budgetary constraints. Anthem does not impose limits on EPSDT services even if not covered under a State Plan Amendment.

All members under age 21 years must receive EPSDT preventive services, including screenings to identify health and developmental issues as early as possible. Appropriate referrals for diagnosis and treatment must be initiated as soon as possible, but no later than 60 days following a preventive screening or other visit that identifies a need for follow-up.

To comply with the Americans with Disabilities Act (ACA) mandate, services must be provided in the most integrated setting possible and in compliance with anti-discrimination laws.

Members are to receive dental screenings/oral health assessments as part of the Initial Health Appointment and at each periodic assessment. Providers must ensure members have a dental home and refer to a dentist, if needed, starting no later than when a child is 12 months of age. Fluoride varnish applied in the primary care and/or dental office and oral fluoride supplementation must be consistent with the Periodicity Schedule. Providers are to refer members to a Medi-Cal dental provider.

Anthem will assist members with appointment scheduling and accessing transportation services, including Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) to and from appointments for all Medically Necessary services.

Anthem informs members/caregivers annually about EPSDT services including the benefits of preventive care, services that are available under EPSDT, where and how to obtain these services, and that necessary transportation and scheduling assistance is available. Members under the age of 21 and/or their caregivers receive Medi-Cal for Kids & Teens Brochures on an annual basis. The Brochures are designed to provide information on preventive care services they will receive during well-child exams based on the following age bands: The Child Brochure for members from birth to age 12 and the Teen Brochure for members aged 12 to 21 years if age. Members and/or caregivers also received a document titled: "Your Medi-Cal Rights" that contains comprehensive information on services they are to receive and steps to take if a service is denied, delayed, reduced, or stopped.

Providers are required to complete a DHCS-developed training on Medi-Cal for Kids & Teens at least every two years. The training includes sections on medical, behavioral, and mental health services that members under age 21 years should receive.

For more information about Medi-Cal for Kids and Teens refer to the following:

- DHCS APL 23-005
- DHCS's Medi-Cal for Kids & Teens
  - Member Information
  - Provider Information
  - Resources
- DHCS's Medi-Cal for Kids & Teens Provider Training
- Anthem's Medi-Cal for Kids & Teens
- Preventive Care/Periodicity Schedule provided by American Academy of Pediatrics.

Childhood Lead Exposure Testing

At each health assessment from 6 months until 72 months of age, providers must conduct and document in medical records, oral or written anticipatory guidance to the parent(s) or guardian(s) of a child that includes the sources of lead exposure and that children can be harmed by any exposure to lead.

DHCS requires that providers order or perform, and document in medical records, blood lead level (BLL) screening tests (capillary or venous sample) on all children enrolled in Medi-Cal, regardless of their risk factors:

- At 12 months and at 24 months of age. Whenever the provider is aware the child has not had a BLL test performed up to 72 months of age.
- Whenever an increased risk for lead exposure is identified.
- When requested by the parent or guardian.

Follow the CDC screening recommendations for all newly arrived refugee infants, children, adolescents, and pregnant and lactating women, which are found on the CDC website > Lead Screening Guidelines: Domestic Guidelines.

PCPs doing Point-of-Care testing must notify the California Department of Public Health (CDPH) of the results of the test. If testing is by a laboratory, they must report 100% of all results. Follow the Management Guidelines on Childhood Lead Poisoning for Health Care Providers for results of 3.5 mcg/dL or higher (link is below).

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

The most up-to-date information on Anthem's BLL Program is located on our website at providers.anthem.com/CA.

For more information, please refer to the CA Department of Public Health Childhood Lead Poisoning Prevention Branch (CLPPB): Management Guidelines on Childhood Lead Poisoning for Health Care Providers.

Member Records, Assessment, and Treatment Planning

Member Records

Member records must meet the standards and contain the elements consistent with the licensure of the provider and are kept confidential as require by state and federal law.

Mental Health Assessment

At any time, members can choose to seek and obtain a mental health assessment from a licensed mental health provider within Anthem' provider network. Also, Anthem will ensure that a mental health screening of members is conducted by network Primary Care Providers (PCP). If a member's PCP cannot perform the mental health assessment, they must refer the member to the appropriate provider and ensure that the referral to the appropriate delivery system for mental health services, either in Anthem' provider network or the county mental health plan's network, is made in accordance with the No Wrong Door policies set forth in W&I (Welfare & Institutions) Code section 14184.402(h) and APL 22-005.

Anthem will cover the cost of an initial mental health assessment completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service within the applicable timely and geographical access requirements set forth in APL 23-001 or subsequent guidance.

Members with positive screening results may be further assessed either by the PCP or by referral to a network mental health provider. The member may then be treated by the PCP within the PCP's scope of practice. When the condition is beyond the PCP's scope of practice, the PCP must refer the member to a mental health provider, first attempting to refer within the Anthem network.

Maternal Mental Health Assessment

To comply with AB 1936, all relevant medical providers, including obstetric specialists, must conduct at least one maternal mental health screening during pregnancy and at least one more within the first six weeks after childbirth. Additional postpartum screenings should be provided if deemed medically necessary and clinically appropriate by the treating provider.

Alcohol and Substance Use Disorder Screening, Referral, and Services

Anthem provides covered SUD services, including alcohol and drug use screening, assessment, brief interventions, and referral to treatment (SABIRT) for members ages 11 and older, including pregnant members, in primary care settings and tobacco, alcohol, and illicit drug screening in accordance with American Academy of Pediatrics Bright Futures for Children recommendations and United States Preventive Services Taskforce grade A and B recommendations for adults as outlined in APL 21-014, Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment.

Further, Anthem provides or arranges for the provision of:

- Medications for Addiction Treatment (also known as Medication-Assisted Treatment or MAT) provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings.
- Emergency services necessary to stabilize the member.

Tuberculosis Screenings

Members 18 years of age or older receiving primary care services must be offered tuberculosis screenings if tuberculosis risk factors are identified. If the screening test is positive, the provider is required to offer the member follow up healthcare or refer them out to receive follow up healthcare.

Personalized Support and Care Plan

A patient-centered support and care plan based on the psychiatric, medical substance use and community functioning assessments found in the initial comprehensive assessment must be completed for any member who receives behavioral health services.

There must be documentation in every case that the member and, as appropriate, their family members, caregivers or legal guardian participated in the development and subsequent reviews of the treatment plan.

The support and care plan must be completed within the first 14 days of admission to behavioral health services and updated every 180 days or more frequently as necessary based on the member's progress toward goals or a significant change in psychiatric symptoms, medical condition and/or community functioning.

There must be a signed release of information to provide information to the member's PCP or evidence that the member refused to provide a signature. There must be documentation that referral to appropriate medical or social support professionals have been made.

A provider who discovers a gap in care is responsible to help the member get that gap in care fulfilled, and documentation should reflect the action taken in this regard.

For providers of multiple services, one comprehensive treatment/care/support plan is acceptable as long as at least one goal is written and updated as appropriate for each of the different services that are being provided to the member.

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

- Identified problem(s) for which the member is seeking treatment
- Member goals related to each problem(s) identified, written in member-friendly language
- Measurable objectives to address the goals identified
- Target dates for completion of objectives
- Responsible parties for each objective
- Specific measurable action steps to accomplish each objective
- Individualized steps for prevention and/or resolution of crisis, which includes identification of crisis triggers (situations, signs and increased symptoms); active steps or self-help methods to prevent, de-escalate or defuse crisis situations; names and phone numbers of contacts who can assist the member in resolving crisis; and the member's preferred treatment options, to include psychopharmacology, in the event of a mental health crisis
- Actions agreed to be taken when progress toward goals is less than originally planned by the member and provider
- Signatures of the member, as well as family members, caregivers or legal guardian as appropriate

Psychotropic Medications

Prescribing providers must inform all members considered for prescription of psychotropic or other medications of the benefits, risks and side effects of the medication, alternate medications, and other forms of non-medication treatment options as consistent with their licensure.

Timeliness of Decisions on Requests for Authorization

Request for Authorization Type	Timeliness of Decision
Urgent, preservice requests	Within 72 hours of request
Urgent concurrent requests	Within 72 hours of request
Routine, nonurgent requests	7 calendar days and up to 14 calendar days when additional information is required. Extension is determined to be in the member's interest.
Retrospective review requests	Within 30 days of request

Access to Care Standards

Standards for timely and appropriate access to quality behavioral healthcare are outlined below:

Type of Care	Access to Care Standard
Emergent	Immediately
Urgent	Within 48 hours of referral/request
Routine outpatient	Within 10 days of request
Outpatient following discharge from an inpatient hospital	Within 7 days of discharge

Definitions

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

Urgent: A service need is not emergent and can be met by providing an assessment and services within 48 hours of the initial contact. If the member is pregnant and has substance use problems, she is to be placed in the urgent category.

Routine: A service need is not urgent and can be met by receiving treatment within 10 calendar days of the assessment without resultant deterioration in the individual's functioning or worsening of their condition.

How to Provide Notification or Request Preauthorization

You may request preauthorization for nonroutine outpatient mental health services that require prior authorization via phone by calling:

- **888-831-2246** 24 hours a day, seven days a week, 365 days a year

Be prepared to provide clinical information in support of the request at the time of the call.

You may request preauthorization via fax, email, or the provider website where available for certain levels of care.

Fax forms are located on our website or via email at:

- providers.anthem.com/CA
- Email: Medi-CalBHUM@Anthem.com

Note: All requests for precertification for psychological and neuropsychological testing, and requests for precertification for ABA should be submitted via fax to **855-473-7902**. Psychological and neuropsychological testing request forms can also be mailed to:

Behavioral Health Department
Anthem
P.O. Box 60007
Los Angeles, CA 90060-0007

Behavioral Health Clinical Authorization and Protocols

The Anthem clinical authorization process is designed to be flexible, providing primary responsiveness to our members' needs while simultaneously allowing the Anthem clinical team to gather information for appropriate medical necessity determinations.

Authorization of medically necessary services within the required time frames is the responsibility of the Anthem licensed behavioral health clinicians. Whenever a clinician questions the appropriateness of the requested level of care, the review is referred to an appropriate behavioral healthcare clinician. Our multidisciplinary team of behavioral healthcare clinicians can include:

- Licensed psychologists
- Licensed professional counselors
- Licensed social workers
- Licensed marriage and family therapists
- Registered psychiatric nurses
- Board certified psychiatrist

These professionals conduct reviews of behavioral health and substance use services to monitor and evaluate treatment requests and progress. They manage utilization, control behavioral healthcare costs and achieve optimal clinical outcomes through a collaborative approach that considers both utilization review data and nationally recognized clinical practice guidelines to determine the appropriate level of care.

Medical Necessity for NSMHS

In accordance with W&I (Welfare & Institutions) Code sections 14059.5 and 14184.402, medical necessity is defined as follows for NSMHS:

for individuals under 21 years of age, a service is “medically necessary” or a “medical necessity” if the service meets the EPSDT standard set forth in Section 1396d(r)(5) of Title 42 of the USC.

for individuals 21 years of age or older, a service is “medically necessary” or a “medical necessity” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

Necessity Determination and Peer Review

- When a provider requests initial or continued authorization for a covered service, our Utilization Managers obtain necessary clinical information and review it to determine if the request meets applicable medical necessity criteria.
- If the information submitted does not appear to meet such criteria, the Utilization Manager submits the information for review by the Medical Director or other appropriate practitioner as part of the peer review process.
- The reviewer or the requesting provider may initiate a peer-to-peer conversation to discuss the relevant clinical information with the clinician working with the member.
- If an adverse decision is made by the reviewer without such a peer-to-peer conversation having taken place (as may occur when the provider is unavailable for review), the provider may request such a conversation. In this case, we will make a Medical Director or other appropriate practitioner available to discuss the case with the requesting provider. This conversation may result in the decision being upheld or changed.
- Members, providers, and applicable facilities are notified of any adverse decision within notification time frames that are based on the type of care requested and in conformance with regulatory and accreditation requirements.

Professional Billing Requirements

Providers rendering covered behavioral health services should bill Anthem using behavioral health CPT® codes. All claims for covered behavioral health services should be billed to Anthem. For more information about proper professional billing procedures, refer to Chapter 14: Claims and Encounters or call 866-398-1922.

Non-Medical Necessity Adverse Decisions (Administrative Adverse Decision)

If you received an administrative adverse determination and think that this decision was in error, see Chapter: 17: Grievances, Appeals, Disputes of this manual for information and instructions on appeals, grievances, and payment disputes.

If you did not receive a precertification for a requested service and think that this decision was in error, see Chapter: 17: Grievances, Appeals, Disputes of this manual for information and instructions on appeals, grievances, and payment disputes.

Avoiding an Adverse Decision

Most administrative adverse decisions result from non-adherence to or a misunderstanding of utilization management policies. Familiarizing yourself and your staff with notification and precertification policies and acting to meet those policies can eliminate the majority of these decisions. Other administrative adverse decisions result from misinformation about the member's status or benefits.

Adverse decisions of a medical nature are rare. Such adverse decisions usually involve a failure of the clinical information to meet evidenced-based national guidelines. We are committed to working with all providers to ensure that such guidelines are understood and easily identifiable for providers. Peer-to-peer conversations (between a Medical Director and the provider clinicians) are one way to ensure the completeness and accuracy of the clinical information.

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

Behavioral Health Clinical Practice Guidelines

All providers have access to evidence-based clinical practice guidelines for a variety of behavioral health disorders commonly seen in primary care. These clinical practice guidelines are located online at providers.anthem.com/CA.

Carved-out Behavioral Health Services

All facility-based behavioral health and substance use disorder services are carved out to the local county department of mental health and the county alcohol and other drug programs:

- Inpatient admissions (IP)
- Intensive Outpatient Program (IOP)
- Partial Hospitalization Program (PHP)
- Residential Treatment Center services (RTC)

Behavioral Health Self-Referrals

Members may self-refer to any behavioral healthcare provider in the Anthem network. If the member is unable or unwilling to access timely services through community providers, call our Customer Care Center for assistance.

Behavioral Health, Alcohol, and Other Drug Program

The following state and county behavioral health services for those with severe level of impairment are available upon referral:

- 24-hour treatment services
- Case management
- Comprehensive evaluation and assessment
- Group services
- Medication education and management
- Outpatient substance use disorders services
- Pre-crisis and crisis services
- Services for homeless persons
- Vocational rehabilitation
- Wraparound services
- Voluntary inpatient detox

For more detailed information on these programs, go to the state's **Department of Health Care Services** > **Mental Health** > **Mental Health Services Division** at dhcs.ca.gov/services/mental-health-services-division.

Inpatient

In-patient mental health services are carved out to the local County Mental Health department. Please contact the County Mental Health Department for any questions.

State and County Services and Programs

The following state and county behavioral health services are available upon referral:

- 24-hour treatment services
- Case management
- Comprehensive evaluation and assessment
- Pre-crisis and crisis services
- Group services
- Medication education and management
- Residential services
- Services for homeless persons
- Vocational rehabilitation

For more detailed information on these programs, go to the state's **Department of Health Care Services** > **Mental Health** > **Mental Health Services Division** at dhcs.ca.gov/services/mental-health-services-division.

Major Organ Transplant

The following major organ transplants covered by Anthem include but are not limited to:

- Bone marrow
- Heart
- Heart/Lung
- Kidney*
- Kidney/Pancreas
- Liver
- Liver/Small bowel
- Lung
- Pancreas
- Small bowel

* minor organ

Transplants for Children Under Age 21

State law requires children who need transplants to be referred to the California Children's Services (CCS) program to see if the child is eligible for CCS. If the child is eligible for CCS, CCS will cover the costs for the transplant and related services.

Pediatric organ transplants that qualify as a CCS-eligible condition are required to be performed only in a CCS-approved Special Care Center (SCC). The SCC must meet the following criteria:

- Have both a CCS program approved center for the specific organ and appropriate pediatric subspecialists on the hospital staff;
- Include the participation of the CCS-paneled pediatric subspecialists with the appropriate specialty for the specific organ, for the care of all patients under the age of 18 years; and
- Admit all patients under the age of 14 years to a pediatric unit or floor.

SCCs by center type can be found at dhcs.ca.gov/services/california-childrens-services/special-care-centers-by-center-type.

If the child is not eligible for CCS, then Anthem will refer the child to a qualified transplant center for evaluation. If the transplant center confirms the transplant would be needed and safe, Anthem will cover the transplant, and all associated medically necessary services. In such cases, Anthem will ensure that the transplant is performed in a Center of Excellence (COE) that has been approved for pediatric major organ transplants.

Transplants for Adults Age 21 and Older

Members identified as potential candidates for Major Organ Transplant are referred to a DHCS approved Transplant Center for evaluation. If the transplant center confirms a transplant is needed and safe, Anthem will cover the transplant and all associated medically necessary services. Adult transplant programs must meet the following criteria:

- Solid Organ transplant programs must meet the Center for Medicare and Medicaid Services (CMS) Conditions of Participation (CoP) for a specific organ type and must maintain an active membership with the Organ Procurement and Transplantation Network (OPTN) administered by the United Network for Organ Sharing (UNOS). A list of current OPTN members can be found at optn.transplant.hrsa.gov/about/search-membership.
- Bone Marrow transplant programs must have current accreditation by the Foundation for the Accreditation of Cellular Therapy (FACT). A list of current FACT accreditations can be found at accredited.factglobal.org.

DHCS requires transplant programs that meet the above criteria to submit an application for consideration to become a Medi-Cal Center of Excellence (COE). If DHCS approves the application, the transplant program is placed on the COE list.

Out-of-State Transplant Program Criteria

Anthem may use CMS approved out-of-state transplant programs for reasons including, but not limited to:

- The member has been receiving services from the out-of-state transplant program for services related to the condition for which the member requires a major organ transplant;
- The member may receive the major organ transplant surgery sooner at the out-of-state transplant program; or
- The out-of-state transplant program is closer to the member than the COE that is within the Anthem network in California

In cases where Anthem approves the member to receive major organ transplant services at an out-of-state transplant program, Anthem will ensure member choice and that the process of referring and coordinating transplants for members to the out-of-state transplant programs is not more restrictive than referring to a COE.

Additionally, Anthem will ensure that out-of-state transplant programs meet the following criteria:

- CMS approval and current OPTN membership for solid organs transplants; or
- FACT accreditation for bone marrow transplants

Sensitive Services

Members do not need prior authorization or a referral and may self-refer for the following sensitive services provided by qualified in-network or out of network providers. For more information, go to static1.squarespace.com/static/66421681d90ded764d1347e8/t/66a9467522a93e5eb03a0380/1722369655524/2023CaMinorConsentConfChartFull.pdf:

- Family planning services including:
- Contraceptive pills, devices, and supplies
- Diagnosis and treatment of sexually transmitted disease
- Health education and counseling
- Laboratory tests
- Limited history and physical examinations
- Pregnancy testing and counseling
- Sterilization
- Annual examination with a network obstetrician/gynecologist
- HIV/STD testing and counseling
- Sexual assault including rape
- Drug or alcohol use for children 12 years of age or older
- Abortion Services
- Outpatient mental healthcare for children 12 years of age or older who are mature enough to participate intelligently and when either:
- There is a danger of serious physical or mental harm to the minor or others
- The children are the alleged victims of incest or child abuse

Abortion Services

Abortion services are covered by the Medi-Cal program. Members may go to any Medi-Cal provider of their choice for abortion services, at any time for any reason, regardless of Network affiliation. Anthem will not deny or interfere with a member's right to choose or obtain an abortion prior to viability of the fetus or when an abortion is necessary to protect the life or health of the pregnant individual.

Anthem does not require a Physician or health care provider to perform or participate in the performance of an abortion. A provider or health care provider will not be subject to penalty or discipline in refusing to perform or participate in performing an abortion.

Assembly Bill 2843

Members can obtain emergency room medical care and follow up health care treatment following a rape or sexual assault for the first 9 months after the initiation of treatment. Members are not required to file a police report, bring charges against an assailant, or assailant to be convicted or rape or sexual assault.

Assembly Bill 2129

Providers are allowed to bill separately for devices, implants, professional services, or any combination of these, related to immediate postpartum contraception if the delivery occurs in a general acute care hospital or licensed birth center. This would be a separate payment from a general obstetric procedure.

Assembly Bill 2091

Providers are prohibited from releasing medical information related to an individual seeking or obtaining an abortion in response to law enforcement for the purpose of enforcement of or in response to a

subpoena to enforce a foreign penal civil action or another state's law that would interfere with a person's rights under the Reproductive Privacy Act.

Assembly Bill 254 and 352

Providers are prohibited from intentionally sharing, selling, using for marketing, or otherwise using any medical information about gender affirming care, abortion, abortion-related services, and contraceptive for any purpose not necessary to providing health care service to a patient.

Health care provider, health plan, pharmaceutical company, contractor, or employer is prohibited from disclosing, transmitting, or granting access to medical information in an electronic health records system or through a health information exchange that would identify an individual and that is related to an individual seeking, obtaining, or aiding in the performance of an abortion to any individual or entity from another state, unless authorized.

Telehealth

Telehealth is a healthcare delivery method that applies high-speed telecommunications systems, computer technology and specialized medical cameras to examine, diagnose, treat, and educate patients at a distance if clinically appropriate.

For example, if clinically appropriate through a telehealth encounter, a patient at a clinic in a rural area may seek medical treatment from a provider or specialist somewhere in California without incurring the expense of traveling to such distant locations.

Other advantages of communicating via telehealth are the following:

- Providers can choose from the Anthem network of specialists, no matter where the member lives, not needing to travel long distances to receive additional care.
- The member does not have to wait long periods of time to schedule an appointment with a specialist.
- The PCP consults electronically with the specialist participating in the telehealth encounter and a recommendation for care can be sent back to the provider and member from a distance therefore care can be continued to be received locally by their provider.

Utilizing telehealth does not require prior authorization. Anthem reimburses for telehealth visits conducted via live audio-only telehealth (in other words, telephone), live video telehealth, or through asynchronous telehealth (in other words, store and forward and e-consults). Telehealth does not include services rendered by fax, or email communication:

- **Live video consult**: The PCP and specialist meet at the same time using encrypted video conferencing equipment.
- **Store and forward**: PCP sends images of the patient's condition and medical history as an encrypted email to the specialist for review.

A healthcare provider may establish a relationship with a new patient via video visits but not via audio-only visit, except for certain circumstances (for example, when the visit is related to "sensitive services" as defined in subsection (n) of Section 56.06 of the Civil Code, or when the patient requests an audio-only modality or attests they do not have access to video).

The member can provide verbal or written consent.

In addition to documenting consent prior to initial delivery of covered services via telehealth, providers are also required to explain the following to members:

- The member's right to access covered services delivered through telehealth.
- That use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the member without affecting their ability to access Medi-Cal Covered Services in the future.
- The availability of non-medical transportation to in-person visits.
- The potential limitations or risks related to receiving covered services through telehealth as compared to an in-person visit, if applicable.

All physicians and other providers offering covered services through video synchronous interaction or audio-only synchronous interaction must also:

- Offer the same services via in-person, face-to-face contact, or
- Arrange for a referral to and facilitation of in-person care.

In addition, providers are required to maintain protocols for patient referral to appropriate in-person care when the standard of care cannot be met by video synchronous interaction or audio-only synchronous interaction.

Referral and facilitation arrangement does not require a provider to schedule an appointment with a different provider on behalf of a patient. In other words, providers are required to make the referral and share clinical data, so the patient does not need to locate a provider on their own. The patient can contact the provider to which they have been referred to schedule the appointment.

Telehealth can also be used for nonclinical consults such as community services, continuing medical education and other provider training sessions. Services for Doula, Community Health Worker (CHW), and Asthma Preventive Services can also be done through Telehealth.

Non-Discrimination Requirements

Providers have a positive responsibility to make sure that telehealth services are accessible to individuals regardless of race, color, national origin, sex, age, or disability. Telehealth services include not only the appointment itself, but all communications about its availability and the process for securing a telehealth appointment. This means that those services also have to be accessible to all individuals, ensuring equitable access to healthcare services, regardless off the method of their delivery.

Telehealth CPT, HCPCS, and Modifiers

For reimbursable services, identified by Current Procedural Terminology (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) may be provided through a telehealth modality if clinically appropriate, verbal, or written consent is given by the member and medical record documentation proves that covered services delivered through telehealth meet the procedural definition and components. Providers are not required to document a barrier to an in person visit for covered services provided through telehealth or document the cost effectiveness.

The covered services provided via telehealth must meet all state and federal laws regarding confidentiality of healthcare information and a member's right to their own medical information.

Providers must designate telehealth modality with an appropriate modifier when billing for telehealth services. For benefits and services provided through synchronous audio-only telecommunications systems (for example, telephone), the provider bills with modifier 93; for synchronous video, modifier 95; and for asynchronous store and forward (including e-consults), modifier GQ).

To find out more about telehealth, use the following contact information:

Location	Contact Information
Los Angelas	**866-465-2272**
Central California and surrounding rural counties	**877-811-3113**
Northern California and surrounding rural counties	**888-252-6331**

For contracting questions, call Provider Services at **877-496-0045**.

LiveHealth Online (LHO)

LiveHealth Online (LHO) is a website and mobile application that gives patients 24/7 access to on-demand video visits (medical). It has an urgent care focus and provides convenient access anytime, anywhere in California (even at home!) via smartphone, tablet, or computer.

LHO connects patients with board-certified physicians supporting physical and behavioral health. Physicians can electronically prescribe to the member's pharmacy. **Note**: Only noncontrolled substances can be prescribed. It is available at no cost for Anthem members enrolled in Medi-Cal Managed Care (Medi-Cal).

LHO does not provide:

- Preventive or ongoing medical care.
- Lab orders.
- Access to specialist care at this time.
- Access to translation services other than Spanish (doctor profiles indicate spoken languages).

Members can get 24/7 help by calling: **888-548-3432** (**888-LIVEHEALTH**).

For urgent prescription assistance after an online visit, members can call: **888-982-7956**.

Transportation

Non-emergency Medical Transportation

Anthem contracted with ModivCare Solutions to coordinate transportation for Anthem members enrolled in Medi-Cal Managed Care (Medi-Cal) in the state of California. ModivCare is responsible for:

- Taking reservations from members, facilities, and medical groups for non-emergency ground transportation
- Contracting with ground transportation providers
- Providing payment for non-emergency ground transportation claims

Members can call **877-931-4755** (**TTY 866-288-3133**) Monday to Friday 7 A.M. to 7 P.M. PT to arrange for authorized transportation through ModivCare. Transportation benefits cover non-emergency medically necessary transportation (NEMT) and non-medical transportation (NMT). ModivCare will ensure timely access for all covered trips. Effective January 1, 2022, members receive medically appropriate NEMT services for all pharmacy prescriptions prescribed by the member's Medi-Cal provider (s) and those authorized under Medi-Cal Rx (per DHCS's Medi-Cal Rx implementation).

Members should schedule ride services at least 5 business days in advance. For long-distance trips, 10 business days in advance. Advance notice is not needed for members who are having an urgent appointment related to Dialysis, chemotherapy, radiation therapy, urgent care, wound care, or facility discharges.

A completed Physician Certification Statement form is required for members to access NEMT and to confirm the appropriate mode of transportation in accordance with the member's medical condition. Physicians must complete the form and return it to ModivCare within two business days of receipt. The form can be found at ModivCare PCS form at providers.anthem.com/california-provider/resources/forms.

Members can call to arrange for transportation through ModivCare.

Emergent Transportation – Ambulance Services

Ambulance services must come from a licensed ambulance or air ambulance company and be used only for emergencies. Coverage includes:

- Base charge and mileage
- Cardiac defibrillation
- CPR
- EKGs
- IV solutions
- Monitoring
- Oxygen
- Supplies

Chapter 5: Member Services, Education, Wellness

Customer Care

Contact	Outside L.A. County	Inside L.A. County
Customer Care Center Phone	**800-407-4627** Monday to Friday, 7 a.m. to 7 p.m.	**888-285-7801** Monday to Friday, 7 a.m. to 7 p.m.

24/7 NurseLine

Questions about healthcare prevention and management don't always come up during office hours. 24/7 NurseLine is a 24-hour-a-day, 7-day-a-week phone line staffed by registered nurses.

24/7 NurseLine allows members to closely monitor and manage their own health by giving them the ability to ask questions whenever they come up.

- 24/7 NurseLine: **800-224-0336 (**TTY: **711)**

Members can call 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 630 healthcare topics through the 24/7 NurseLine audio tape library
- Assistance in finding an in-network provider

Members can also call our 24/7 NurseLine anytime to speak to a registered nurse. Nurses provide health information and options for any of the following:

- Emergency instructions
- Health concerns
- Local healthcare services
- Medical conditions
- Prescription drugs
- Access to interpreter services

Wellness Programs

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

These targeted programs are designed to supplement providers' treatment plans and include multiple categories such as:

- **Preventive Care Programs** for all members including the Initial Health Appointment and Well Woman programs and vaccines when recommended by the ACIP
- **Health Education** including the **24/7 NurseLine** for all health-related questions
- **Emergency Room Initiative** that instructs members on the proper use of emergency room services

- **Wellness Programs** that promote knowledge on self-care for targeted medical conditions and chronic disease

We introduce new members to these programs through a new member packet, which includes preventive healthcare guidelines and a Member Services Guide that includes information on how to access health education services.

After that, we use a variety of methods and informal settings to inform our members about available health services including:

- Direct mailings
- Health education classes
- Telephone calls
- Health fairs and community events

Tobacco Cessation Programs

Anthem supports smoking cessation for members who want to become smoke-free by:

- Assisting members in improving their health status and quality of life by becoming more actively involved in their own care.
- Encouraging members to quit using tobacco.
- Supporting members' tobacco cessation efforts with resources, referral programs and education.

Tobacco cessation/information available to members:

- California Smokers' Helpline offers free telephonic counseling, self-help materials and online help in six languages: California Smokers' Helpline:
  - **800-662-8887** (**800-NO-BUTTS**)
  - kickitca.org

American Lung Association Freedom from Smoking offers telephonic counseling, in-person group clinics and online resources at lung.org/stop-smoking/join-freedom-from-smoking.

Note: Enrollment in tobacco counseling is not required in order to obtain tobacco cessation materials.

Provider Assessment of Tobacco Use

Providers are required to implement the tobacco cessation interventions as outlined in the revised All Plan Letter 16-014 dated November 30, 2016, from the California Department of Health Care Services.

These interventions include conducting initial and annual assessments of all members of any age who use tobacco products or are exposed to tobacco smoke and document this information in the member's medical record.

Using the Staying Healthy Assessment or other IHEBA at each age-appropriate interval to identify and track smoking status and/or exposure to tobacco smoke.

- Ask tobacco users about their current tobacco use at every visit and document. Prescribe Food and Drug Administration (FDA) approved tobacco cessation medications to non-pregnant adults of any age.

Note: Medi-Cal plans shall cover all FDA approved tobacco cessation medications for adults who use tobacco products. This includes over-the-counter medications with a prescription from the provider. For more information, review the guide at providers.anthem.com/docs/gpp/california-provider/CA_CAID_TobaccoUseGuide.pdf.

Medi-Cal covers the following without prior authorization:

- Nicotine patches
- Nicotine gum
- Nicotine lozenges
- Bupropion SR (Zyban) - covered under Medi-Cal Rx without PA
- Nicotine nasal spray Varenicline (Chantix) - covered under Medi-Cal Rx without PA

Medi-Cal covers the following with prior authorization:

- Nicotine inhaler
- Refer tobacco users of any age to available individual, group and telephonic counseling. Anthem members qualify for four counseling sessions of at least ten minutes for at least two separate quit attempts each year without prior authorization.

Providers can:

- Refer to available community programs.
- Ask all pregnant women if they use tobacco or are exposed to tobacco smoke. If they smoke, offer at least one face-to-face counseling session per quit attempt and refer to a tobacco cessation quit line. Counseling services will be covered for 60 days after delivery. Smoking cessation medications are not recommended during pregnancy. Providers shall refer to the tobacco cessation guidelines by the American College of Obstetrics and Gynecology (ACOG).
- Use the 5A's Model or other validated behavior change model when counseling members.
- Refer a member to the no-cost CA Smoker's Helpline at **800-NO-BUTTS** or another any other comparable quit- line.
- Provide education including brief counseling to children and adolescents to prevent initiation of tobacco in school-aged children and adolescents. Providers shall follow the American Academy of Pediatrics guidance on tobacco including the provision of anticipatory guidance.

Anthem will monitor provider performance in implementing these tobacco cessation services through various processes comprising of periodic medical record reviews, and review of medical or pharmacy claims data.

Providers can read All Plan Letter 16-014 on the DHCS website at dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-014.pdf.

The Smoking Cessation Leadership Center is a national program that collaborates with health professionals and institutions to increase their competency in helping smokers quit. They provide various types of resources including curriculums, presentations, online training, publications, toolkits, and webinars for continuing education.

If you are interested in tobacco cessation updates through the aforementioned outlets, visit smokingcessationleadership.ucsf.edu.

For additional information and provider training resources, visit the Anthem tobacco cessation webpage at providers.anthem.com/california-provider/resources/provider-training-academy.

Emergency Room (ER) Action Campaign

The Anthem ER Action Campaign identifies members who visit the emergency room for non-emergency services that can be better managed at their doctor's office or an urgent care center. With this campaign, we can help patients know that non-emergency, preventive, and follow-up care should always start with their doctor.

The ER Action Campaign teaches members about:

- Seeking care for non-emergency events
- Contacting their doctor first before going to the ER
- Alternatives to ER use
- Importance of follow-up care by their PCPs

Our ER Action Campaign relies on the support of providers like you, who remind patients that their doctor's office and our 24/7 NurseLine should be their first call for non-emergency conditions. Working together, we can help your patients get appropriate care and avoid the long wait times and high costs often associated with ER visits and encourage a strong relationship with you, their primary doctor.

Health Education No-Cost Classes

Anthem offers health education services and programs to meet the specific health needs of our members, promote healthy lifestyles, and improve the health of those living with chronic diseases. Health education classes take place at hospitals and/or community-based organizations. Classes are available at no charge to the member and are available upon self-referral or referral by Anthem providers. Classes vary from county to county and include the following topics:

- Asthma management
- Breastfeeding education
- Diabetes management
- Exercise
- Family planning
- HIV/STD control
- Hypertension/heart disease education
- Injury prevention
- Nutrition
- Obesity
- Parenting
- Perinatal education
- Smoking cessation/tobacco prevention
- Substance use

Members receive information about health education classes through enrollment materials, member website, and information made available at their provider's office.

Health Education Referral

Providers can refer members to health education classes using the **Health Education & Cultural and Linguistic Referral form** on our provider website.

The form is located within the health education site at **providers.anthem.com/california-provider/resources/forms**.

To schedule a health education class, members should call our Customer Care Centers.
If the member receives one-on-one counseling from an Anthem Health Educator, Anthem sends a confirmation letter to the member's PCP with the following information:

- Member's name
- Member's ID number
- Topic discussed

If the provider administers health education to the member, it must be documented in the member's medical record. Documentation must include the following:

- Education topic
- Identification of person providing the education
- Materials distributed to the member
- Notation of any follow-up or recommendations

If a member is referred for one-on-one health education counseling and the Health Educator is unable to reach them after multiple attempts, Anthem sends an Unable to Reach letter to the member's PCP. Similarly, if the referred member declines health education counseling, Anthem will send a letter notifying the provider.

Diabetes Prevention Program

Medi-Cal Managed Care (Medi-Cal) members at risk for type 2 diabetes have access to the Centers for Disease Control and Prevention (CDC) Diabetes Prevention Program (DPP) through a new member benefit. DPP has been proven by the National Institute of Health (NIH) in a randomized controlled trial to greatly reduce the progression of prediabetes to type 2 diabetes. Services are delivered by trained lifestyle coaches and organizations recognized by the CDC at no cost to the member.

The DPP is a year-long program that consists of weekly sessions with a lifestyle coach for the first six months and monthly maintenance sessions for the latter six months. Sessions can be held in a group classroom setting or online. Participants will learn realistic lifestyle changes emphasizing weight loss through exercise, healthy eating, and behavior modification.

Member eligibility criteria include:

- At least 18 years of age
- BMI of 25 or greater:
  - If member is of Asian descent, a BMI of 23 or greater is required.
- Blood screening (optional, if available):
- Hemoglobin A1C: 5.7% to 6.4%
- Fasting plasma glucose: 100 to 125 mg/dL
- Oral Glucose Tolerance Test: 140 to 199 mg/dL

Exclusions include no previous diagnosis of end-stage renal disease or type 1 or type 2 diabetes; not pregnant (previous gestational diabetes is not an exclusion).

Providers can also direct members to take the online risk assessment at solera4me.com/AnthemBC_MediCal or by calling **833-516-4483** to determine eligibility and enroll in the DPP.

Health Education Materials for Your Office

Health education materials including health topic-specific brochures such as Diabetes, Asthma, Smoking, Pregnancy and Baby's Health, Exercise, and Nutrition can be found on the Anthem provider website at the beginning of this section.

Under *Provider Support*, you will also find links to other valuable resources such as cultural and linguistic tools, perinatal education brochures, and information regarding breastfeeding promotion. All these resources may be downloaded. You may also request hard copies of these materials by calling Provider Relations at the number(s) listed at the beginning of this chapter.

Culturally and Linguistically Appropriate Services

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

The U.S. Department of Health and Human Services (HHS) defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. It is a dynamic, ongoing developmental process requiring long-term commitment. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains that healthcare is defined through a cultural lens for both patients and providers. A person's cultural affiliations can influence:

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

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

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

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

Anthem ensures providers have access to resources to help support delivery of culturally and linguistically appropriate services, and encourages providers to access and use the following resources available at providers.anthem.com/california-provider/resources/provider-training-academy.

Our Cultural Diversity and Linguistic Services Toolkit called Caring for Diverse Populations was developed to give you specific tools for breaking through cultural and language barriers in an effort to better communicate with your patients. Download the toolkit at providers.anthem.com/docs/gpp/california-provider/CA_CAID_CaringforDiversePopulationToolkit.pdf.

This toolkit gives you the information you'll need to continue building trust. It will enhance your ability to communicate with ease, talking to a wide range of people about a variety of culturally sensitive topics. And it offers cultural and linguistic training to your office staff so that all aspects of an office visit can go smoothly.

The toolkit contents are organized into the following sections:

Section	Description
Improving communications with a diverse patient base	• Encounter tips for providers and their clinical staff • A memory aid to assist with patient interviews • Help in identifying literacy problems
Tools and training for your office in caring for a diverse patient base	• Interview guide for hiring clinical staff who have an awareness of cultural competency issues • Americans with Disabilities Act (ADA) requirements
Resources to communicate across language barriers	• Tips for locating and working with interpreters • Common signs and common sentences in many languages

Section	Description
	• Language identification flashcards • Language skill self-assessment tools
Resources to increase awareness on how cultural background impacts healthcare delivery	• Tips for talking with people across cultures about a variety of culturally sensitive topics • Information about healthcare beliefs of different cultural backgrounds
Regulations and standards for cultural and linguistic services	• Identifies important legislation impacting cultural and linguistic services including a summary of the Culturally and Linguistically Appropriate Services (CLAS) standards, which serve as a guide on how to meet these requirements
Resources for cultural and linguistic services	• Cultural competency web-based resources

The toolkit contains materials developed by and used with the permission of the Industry Collaboration Effort (ICE) Cultural and Linguistic Workgroup, a volunteer, multidisciplinary team of providers, health plans, associations, state and federal agencies, and accrediting bodies working collaboratively to improve healthcare regulatory compliance through public education.
iceforhealth.org.

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.

The My Diverse Patients 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:

Offering	Description
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, and 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 and learn techniques to improve

Offering	Description
	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 and 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.

Access the My Diverse Patients website for the CME credit trainings mentioned above plus more at mydiversepatients.com.

Anthem offers additional resources to support provision of culturally and linguistically appropriate services, including My Diverse Patients and a Cultural Competency Training, which can be accessed at providers.anthem.com/california-provider/resources/provider-training-academy.

Diversity, Equity, and Inclusion (DEI) Training

In alignment with the timeline presented in APL 24-016 Appendix A, Anthem has developed a Diversity, Equity, and Inclusion (DEI) training program that includes pillars of sensitivity, diversity, cultural competency, cultural humility, and health equity. This requirement applies to all our network providers, irrespective of their cultural or professional training and background. The training encompasses various attributes such as sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental and physical disabilities, medical conditions, genetic information, health status, marital status, gender identity, sexual orientation, or association with any groups as defined in Penal Code section 422.56, specific to each region. Additionally, the DEI training program adheres to the National Committee for Quality Assurance (NCQA) Health Equity Accreditation Standards. Access the training.

If you have finished the training with another health plan, let us know by completing this form.

Transgender, Gender Non-conforming or Intersex (TGI) Training

In alignment with the requirements set forth in APL 24-017, Anthem requires all subcontractors and downstream subcontractors who have direct interaction—including oral and/or written communication—with members during the delivery of care or member services to complete evidence-based cultural competency training. This training is designed to provide trans-inclusive healthcare for individuals identifying as transgender, gender non-conforming, or intersex (TGI) and must be completed every two years, or more frequently if necessary. Training resources can be accessed here.

Language Capability of Providers and Office Staff

Anthem strives to have a provider network that can meet the linguistic needs of our members. An important component of that is having network providers that are aware of the language capabilities of themselves and their office staff.

Providers must notify members of the availability of interpreter services and strongly discourage the use of friends and family members, especially children, acting as interpreters. Under the Federal guidance, published as section 1557 of the Affordable Care Act, providers are required to use qualified interpreters while interacting with members with limited English proficiency.

As defined in Section 1557, a "qualified interpreter" for an individual with limited English proficiency means an interpreter who provides interpretation services via a remote interpreting service or an onsite appearance. It is a requirement that a qualified interpreter:

A. Adheres to generally accepted interpreter ethics principles including client confidentiality.
B. Has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language.
C. Is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology, and phraseology.

Clear site-specific written policies shall be in place that delineate appropriate use of bilingual staff, contract interpreters and translators to ensure quality and effective use of resources.

Multilingual staff should self-assess their non-English language speaking and understanding skills prior to interpreting on the job.

Be sure to provide annual updates on the language capabilities of your office staff and at least every three years for yourself by downloading the Employee Language Skills Self-Assessment Tool by selecting the link at providers.anthem.com/docs/gpp/california-provider/CA_CAID_LanguageSkillsSelfAssessmentTool.pdf.

This information will be reported in the provider directory to help members find a provider and/or office staff that speaks their preferred language.

Interpreter Services

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. It is important that you or your office staff document the member's language, any refusal of interpreter services and requests to use a family member or friend as an interpreter in the member's medical record.

Face-to-face interpreters for members needing language assistance during the member's scheduled in office appointment including American Sign Language are available at no cost to the provider or member by placing a request at least 72 hours in advance. A 24-hour cancelation notice is required.

Over-the-phone interpreters are available 24 hours a day, 7 days a week.

To obtain free interpreting services, call our Customer Care centers.

For after-hours telephone interpreter services, call the 24/7 NurseLine at **800-224-0336 (TTY 711)** and take the following steps:

1. Give the customer care associate the member's ID number.
2. Explain the need for an interpreter and state the language.
3. Wait on the line while the connection is made.
4. Once connected to the interpreter, the associate or 24/7 NurseLine nurse introduces the Medi-Cal member, explains the reason for the call and begins the dialogue.

Request/Refusal of Interpreter Services forms are available in threshold languages on our provider website at providers.anthem.com/california-provider/resources/forms > **Patient Care**.

Hearing Loss, Visual and/or Speech Impairment Services

During business hours, members with hearing loss or speech impairment can call the following numbers:

Description	Phone
Voice to TTY (English)	**711 or 800-735-2922**
Voice to TTY (Spanish):	**800-855-3000**
TTY to Voice (English)	**800-735-2929**
TTY to Voice (Spanish)	**800-855-3000**
After regular business hours	Members can call the 24/7 NurseLine TTY number at **800-368-4424**

For additional information, visit the California Relay Service webpage at caconnect.org.

Members with visual impairments can request verbal assistance or alternative formats for assistance with printed materials at no cost to the member.

Translation of Materials

Members can request translation of materials into non-English languages and alternative formats at no cost to them by contacting the designated Customer Call Center number in Chapter 2: Quick Reference, in the Contact Information section.

Cultural and/or Linguistic Referral

Providers can make a cultural and /or linguistic referral using the Health Education and Cultural and Linguistic Referral form on our provider website.

The form is located within the health education site at providers.anthem.com/california-provider/resources/forms > **Patient Care**.

Member Rights and Responsibilities

The members of the Anthem Medi-Cal should be clearly informed about their rights and responsibilities in order to make the best healthcare decisions. That includes the right to ask questions about the way we conduct business as well as the responsibility to learn about their healthcare plan.

Members have certain rights and responsibilities when receiving their healthcare. They also have a responsibility to take an active role in their care.

As their healthcare partner, we are committed to making sure their rights are respected while we provide their health benefits. This also means giving them access to our network providers and the information they need to make the best decisions for their health and welfare.

The following are our members' rights and responsibilities as stated in each of the member handbooks. They are also posted on our website at mss.anthem.com/california-medicaid/caca_mc_memberhandbook_eng.pdf.

Advance Directives

Anthem recognizes 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 in the event that they become incapacitated. Providers may be asked to assist members in procuring and completing the necessary forms.

Advance directive documents should be on hand in the event a member requests this information. Members, over the age of 18 years, will be asked by the provider if they are aware of advance directives or want more information. This information will be documented in the chart.

Medi-Cal

Our members have the right to:

- Be treated with respect, giving due consideration to the member's right to privacy and the need to maintain confidentiality of the member's medical information.
- Have access to, and where legally appropriate, receive copies of, amend or correct their medical record.
- Be free to exercise these rights without adversely affecting how they are treated by Contractor, providers, or the State.
- Receive information about the health plan, its services, its practitioners and providers and member rights and responsibilities.
- Receive written information in alternative formats (including audio CD, large print and braille) at no cost to them upon
- Do what they think is best for their healthcare without anyone stopping them. They may make health decisions without fear of retaliation from their doctor or health plan.
- Make an advance directive (also known as a living will).
- Get a range of covered services.
- Get family planning services.
- Be treated for STIs.
- Access minor consent services if they are under 18 years of age.
- Obtain emergency care outside of the Anthem network as federal law allows.
- Have access to family planning services, Federally Qualified Health Centers, American Indian Health Programs, sexually

request and in a timely way that is correct for the format that they asked for.
- Obtain member materials in a language other than English at no cost to them.
- Receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition and ability to understand, regardless of cost or benefit coverage.
- Expect us to keep private their personal health information. This is as long as it follows state and federal laws and our privacy policies.
- Be free of any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Choose their PCP.
- Refuse care or treatment from their PCP or other caregivers.
- Work with their doctors in making choices about their healthcare.

transmitted disease services and emergency services outside the contractor's network pursuant to the federal law.
- To receive oral interpretation services for their language at no cost to them.
- Tell us how they would like to change this health plan, including changes to the member's rights and responsibilities.
- To voice grievances or appeals, either verbally or in writing, about the organization or the care received.
- To participate in decision making regarding their own healthcare including the right to refuse treatment. Ask the Department of Social Services for a state hearing.
- Ask the Department of Managed Health Care for an independent medical review.
- Choose to leave this health plan.

Members have the responsibility to:

- Give us, their doctors and other healthcare providers the information needed (to the best of their ability) to help them get the best possible care and all other benefits to which they are entitled.
- Understand their health problems as well as they can and work with their doctors or other healthcare providers to make a treatment plan they all agree on.
- Follow the care plan that they have agreed on with their doctor and other healthcare providers.
- Follow their doctor's advice about taking good care of their selves.
- Use the right sources of care.
- Bring their health plan ID card with them when they visit their doctor.
- Treat their doctors and other caregivers with respect.
- Understand their health plan.
- Know and follow the rules of their health plan.
- Know that laws govern their health plan and the types of service they get.

Know we cannot discriminate against them because of their age, sex, race, national origin, culture, language needs, sexual orientation, or health.

Chapter 6: Pharmacy

Coverage and Limitations

Eligibility

As of January 1, 2022, the Medi-Cal pharmacy benefit is provided through fee-for service (Medi-Cal Rx) and administered by Prime Therapeutics, prescription drugs without a copay or deductible are a covered Medi-Cal benefit if the following conditions are met:

- The drug is prescribed by an appropriate and licensed clinician.
- The drug is used for the care and treatment of an injury or illness.
- The drug is pre-approved by Medi-Cal Rx when it is not included on the Contracted Drug List (CDL).
- The drug is approved for human use by the Food and Drug Administration (FDA).

Pharmacy Network

Members must have their prescriptions filled by drugstores within the Medi-Cal Rx pharmacy network.

- To verify pharmacy network participation or Medi-Cal Rx drug coverage, call **800-977-2273** or visit the Medi-Cal Rx Pharmacy Locator online tool at medi-calrx.dhcs.ca.gov.

Pharmacy Member Cost Sharing

Members enrolled in Medi-Cal do not have a copay nor deductible for covered prescription drugs.

Pharmacy Benefit Exclusions

The following medications are not covered by the pharmacy benefit:

- Non-CMS OBRA rebateable drugs unless indicated by the state
- Medications used for cosmetic reasons (including hair growth)
- Medications used for infertility
- Medications used for weight loss
- Drugs used for erectile dysfunction or sexual enhancement
- Drugs not approved by the FDA
- DESI drugs
- Unit-dose (UD) and repackaged drugs
- Experimental or investigational drugs
- Dietary supplements (except PKU treatments)
- Dietary supplements (except PKU treatments)

Quantity Limits

Certain medications are subject to quantity limits. A quantity limit establishes the maximum amount of medication that is covered within a defined period of time.

Generally, the quantity limits are established based upon manufacturer or FDA dosing recommendations. If a member has a medical condition that requires exceeding the limit, a prior authorization request containing documentation of medical need for consideration will be required.

Pharmacy Benefit Carveouts

As of January 1, 2022, medications are administered by the state through Magellan and reimbursed by fee-for-service (FFS) Medi-Cal.

As of January 1, 2022, providers will need to follow the state Medi-Cal fee-for-service contract drug list. This list is posted on the Medi-Cal Rx website at Medi-CalRx.dhcs.ca.gov.

Over-the-counter Drug Pharmacy Benefit

Medi-Cal follows the fee-for-service over the counter (OTC) drug list. The FFS OTC drug list is available online on the California Medi-Cal Pharmacy webpage at Medi-CalRx.dhcs.ca.gov.

Preferred Drug List

As of January 1, 2022, providers will need to follow the state Medi-Cal Fee-For-Service Contracted Drug List. This list is posted on the Medi-Cal Rx website at Medi-CalRx.dhcs.ca.gov.

Prior Authorizations

The Prior Authorization (PA) program is one of the most widely used, cost-effective methods for managing inappropriate drug use and increasing drug costs.

The PA programs are developed by the Clinical Pharmacy Service team and presented to the Pharmacy and Therapeutics (P&T) Committee for review and approval.

Drugs are selected for PA based on quality-of-care issues, cost and/or utilization trends. The PA program complies with Section 1927 (d) of the Social Security Act. PAs may be used under the following conditions:

- For prescribing and dispensing medically necessary non-formulary drugs
- To limit drug coverage consistent with the provisions of the Medicaid contract
- To minimize potential drug over-utilization
- To accommodate exceptions to Medicaid drug utilization review standards related to proper maintenance drug therapy
- To ensure appropriate utilization of medical injectable, specialty and oncology products that are typically administered as a component of the medical benefit (office injections only)

Clinical policies and procedures are developed by the Clinical Pharmacy Service team to define applicable criteria to allow coverage for drugs subject to one of the above conditions. These policies and procedures are reviewed and approved by the P&T Committee. Where states have specific requirements, their criteria and management programs are implemented.

The decision to approve or deny the request for PA is made within 24 hours of receipt of all necessary information. If the prescriber has not responded to the Pharmacy department's request to obtain the information needed to make the decision within 72 hours, the decision time frame will have expired, and notice will be provided to the prescriber and member.

If the request is denied, the prescriber and member are notified. In addition, a letter indicating the reason for the denial/noncertification is sent to the member and prescriber within 24 hours of rendering the decision, and the denial/noncertification letter includes the appeals procedure. A copy of the denial/noncertification letter is maintained on file in the Pharmacy department.

All PA requests are processed and recorded using a web-based application maintained by Anthem. This database is used for reporting such requests, approvals and denials/noncertifications for monthly and quarterly reports as well as state required reports.

The Anthem PA process continuously monitors the exception process and trends are reviewed by the P&T Committee. These reviews evaluate the consistency of management and timeliness of review and authorization.

Anthem contracts with the pharmacy benefit manager (PBM) for the processing of PAs using the state's required criteria as well as required turnaround times.

Peer-to-peer Review

Providers may request a peer-to-peer review with a Medical Director to discuss PA decisions by calling Anthem at **833-293-0659, option 2**. In this case, we will make a Medical Director available to discuss the case with the requesting provider. This conversation may result in the decision being upheld or changed.

Self-Injectable Medications

Anthem has delegation arrangements with certain participating medical groups (PMGs) who agree to provide their assigned members' self-injectable medications. Typically, the medical provider's group has an arrangement with a specialty pharmacy which can supply the patient's medication.

Physician-administered Drugs

Physician-administered drugs are typically billed using HCPCS codes. Coverage policies must be obtained by contacting Anthem Utilization Management.

Opiate Prescribing

Follow Medi-Cal Rx policies.

Special Fill Procedures

Pharmacy Emergency Supplies

- Beginning February 6, 2022, dispensing of a 14-day emergency supply of any medication for which delaying the dispensing would withhold a medically necessary service is permitted electronically and via paper claim without requirement for a PA.
    - Electronically billed emergency drug dispensing claims will be limited to a 14-day supply and a limit of 2 fills in a 30-day period for the same drug and dose, which will allow for beneficiaries to have immediate access to medically necessary drugs in emergency situations.
    - If the situation requires a larger supply to be dispensed, the provider must submit a paper claim for the service. All products are available provided they are benefits of the program, including those that require a PA or Code 1 approval.
    - Any policy reject codes may be overridden for emergency purposes with the exception of any eligibility edits (including those with a SOC) and OHC reject codes.
    - Unbreakable packages such as inhalers, vials, oral contraceptives, will continue to be paid for the full package size even when the days' supply exceeds 14 days. Emergency fills will be subject to audits, and providers are required to retain documentation of the emergency circumstances for audit purposes
- The Pharmacy must call Medi-Cal Rx at **800-977-2273** for a prescription override to submit the 72-hour medication emergency supply for payment

Excluded and carved-out medications/products are not eligible for a 14-day emergency supply.

Lost or Stolen Medications

PA may be considered in life-threatening situations and for maintenance medications only when the following conditions are met:

- The member must provide detailed information regarding how the medication was lost or stolen.
- Based on clinical judgment of the reviewing clinical pharmacist, contact may be made with the prescriber to confirm their knowledge of the situation and the approval for replacement medication.
- If the medication was stolen, a copy of the official police report will be required.
- Habitual requests for replacement medications will be referred to the health plan Medical Director and/or Medicaid Special Investigations Unit.

Pharmacy Programs

Prescription Drug Monitoring Program

Medi-Cal Rx does not routinely provide payment for replacement of lost, stolen or otherwise destroyed medications, even if a physician writes a new prescription for the medication. It is the responsibility of the member to replace these medications.

Prescribers and dispensers are encouraged to register for Controlled Substance Utilization Review and Evaluation System (CURES) access as soon as possible in observance of mandates established by CA SB809 and SB482.

California Health & Safety Code section 11165.1 (a)(1)(A) states that healthcare practitioners authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III or Schedule IV controlled substances and pharmacists must submit an application for approval to access information online regarding the controlled substance history of a patient.

Providers should review six-month prescription profiles and/or California prescription drug monitoring program (CURES) report with the member, pointing out the importance of appropriate drug use and avoidance of drug interactions. SB482 requires providers to consult CURES in advance of prescribing certain controlled substances.

More information about CURES, including registration information, is available at oag.ca.gov/cures.

Coordination of Benefits

Medicaid is the payer of last resort. In order to properly adjudicate pharmacy claims, the pharmacy claims system also edits for coordination of benefits (COB) using a COB flag that is sent on the member eligibility record.

Following NCPDP standards, the pharmacy enters certain codes indicating payment made by the primary insurer, and Anthem covers the member's remaining out-of-pocket expense. For members with commercial primary coverage, Anthem can cover member prescription deductibles and copays:

- For members with Medicare Part B, Anthem can cover the member's 20% cost share.
- For members with Medicare Part D, Anthem covers select drugs which are covered by Medicaid but not Medicare Part D.

Anthem does not cover Part D deductibles, copays, or catastrophic member cost share payments. These resources include but are not limited to: FDA-approved product labeling, peer-reviewed literature, and American Hospital Formulary Service.

Chapter 7: Special Programs

Managed Long-term Services and Supports

Managed Long-Term Services and Supports (MLTSS) consists of a variety of state of California programs that provide services to help individuals remain living independently in the community or the most appropriate setting of their choice. MLTSS are provided over an extended period, predominantly in the member's home or community, but also in facility-based settings such as nursing facilities.

MLTSS consists of:

- Long-term Care (LTC)
- Community-Based Adult Services (CBAS)

Medi-Cal beneficiaries, including dual eligible, must join a Medi-Cal managed care health plan like Anthem to receive MLTSS benefits.

By providing MLTSS and connecting members to other home- and community-based services (HCBS), Anthem works to ensure that members are getting the right care, in the right place, and at the right time.

Supportive Services (IHSS) and Multipurpose Senior Service Program (MSSP) are available to members as carved-out services.

Consumer Direction

MLTSS are provided under models that promote consumer direction. Members have a voice in how eligible MLTSS services are provided, who provides the services, and what goals they want prioritized within their MLTSS plans of care.

MLTSS Service Coordination

The Anthem MLTSS team works to support member choice and independence by providing access to and coordination of services and supports. This allows members to live with dignity in their community or LTC facility, improving their quality of life.

To ensure members' needs are being met, MLTSS staff work closely with our Case Management and Behavioral Health teams, PCPs, and MLTSS providers to identify and connect with members who could benefit from MLTSS services. This includes:

- Identification of needs through the review of Health Risk Assessments and other member Assessments
- Review and processing of referrals from PCP, specialists and MLTSS providers
- Coordination with members, family, providers and case managers as needed to implement a plan of care
- Review of MLTSS provider care plans and coordination with providers on additional support
- Assistance in determining the right combination of MLTSS supports
- Assistance in accessing MLTSS and other home- and community-based services
- Assistance with caregiver issues, community resource referrals, emergency needs, financial assistance, housing arrangements, long-term care planning and nursing home placement discussions
- Assistance with transitions from skilled nursing facilities back to the community

In-home Supportive Services

In-home Supportive Services (IHSS) allows eligible seniors and persons with disabilities to hire a homecare worker to assist them with their activities of daily living, instrumental activities of daily living and other personal needs so they can remain safely in their homes. Members receiving IHSS self-direct their own care by hiring, managing and, if necessary, firing their homecare workers. Members can also elect to involve their IHSS homecare workers as members of their care teams.

Types of Services Provided by IHSS Homecare Workers

Examples of services that can be provided by IHSS homecare workers include:

- Domestic and related services (in other words, house cleaning/chores, meal preparation and clean-up, laundry, grocery shopping, heavy cleaning)
- Personal care services (in other words, bathing and grooming, dressing, feeding)
- Paramedical services (in other words, administration of medication, puncturing skin, range of motion exercises)
- Other services (in other words, accompaniment to medical appointments, yard hazard abatement, protective supervision)

IHSS Eligibility and Referral Process

To be eligible for IHSS, a member must:

- Reside in California, be a U.S. citizen/legal resident, and be living in their own home.
- Be eligible to receive Medi-Cal benefits.
- Be 65 years of age or older, legally blind, or disabled by Social Security standards.
- Submit a healthcare certification form (SOC 873) signed by a licensed healthcare professional indicating that they need assistance to stay living at home.

The IHSS program is administered by the county, and county social workers are responsible for assessing, approving, and authorizing service hours based on the needs of the member.

The county (or delegated IHSS Public Authority) is also responsible for screening and enrolling IHSS homecare workers, conducting criminal background checks, conducting homecare worker orientations, operating homecare worker registries, and retaining enrollment documentation.

Members who may benefit from IHSS or who need assistance navigating the program can contact an Anthem MLTSS Service Coordinator at **855-871-4899**.

Members may also self-refer and apply directly with the county by calling the IHSS Application Hotline in their county (cdss.ca.gov/inforesources/county-ihss-offices) at:

- **530-694-2235** (Alpine)
- **844-835-3685** (Amador)
- **209-754-6544** (Calaveras)
- **530-642-4800** (El Dorado)
- **855-832-8082** (Fresno)
- **760-873-6364** (Inyo)
- **661-868-1000** (Kern)
- **559-852-4467** (Kings)
- **888-944-IHSS** (Los Angeles County)
- **559-662-2600** (Madera)
- **760-924-1770** (Mono)
- **916-874-9471** (Sacramento)
- **415-355-6700** (San Francisco)
- **408-792-1600** (Santa Clara County)
- **866-376-7066** (Tulare)
- **209-533-5711** (Tuolumne)

Intermediate Care Facilities for Developmentally Disabled (ICF/DD)

In accordance with APL 24-011, intermediate care facility benefits are available to members residing in all counties that Anthem serves that have ICF/DD facilities. Anthem, authorizes and covers medically necessary services provided in an intermediate care facilities for the developmentally disabled consistent with the definitions provided by DHCS including:

- Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Homes
- Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) Homes
- Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N) Homes

"Facility" and "home" are interchangeable terms for an ICF/DD facility.

Members in need of ICF/DD services will be placed in a health care facility that provides the level of care most appropriate for the member's needs. Members retain their rights under the Lanterman Act including the roles and responsibilities of the local Regional Center to certify medical necessity and placements.

Members who are admitted into an ICF/DD Home will remain enrolled in Anthem instead of being enrolled in Fee for Services (FFS) Medi-Cal.

Timely Processing and Payment of Claims

Anthem will pay all claims within contractually mandated statutory timeframes and in accordance with the timely payment standards in the Contract for clean claims within 30 calendar days of receipt. If Anthem does not pay a clean claim within 30 calendar days of receipt, Anthem will owe the provider interest at the rate of 15 percent per annum beginning on the first day after the 30 calendar-day period.

Explanation of Benefits/Remittance Advice

To ensure that ICF/DD Homes have sufficient details for auditing and cost reporting purposes, Anthem includes the following details in the remittance advice provided to ICF/DD Home providers:

1. **Recipient Name**: Listed last name first.
2. **Recipient Medi-Cal I.D. No**: The recipient Medi-Cal identification number.
3. **Claim Control Number**: A unique 13-digit number assigned by the California MMIS Fiscal Intermediary to track each claim line or CIF. (Optional)
4. **Service Dates**: Date(s) that service was rendered to a recipient.
5. **Rev Cd**: The Revenue Code that appears on the claim will be shown.
6. **ACCM/MCRT**: If an existing/local accommodation code was billed, the accommodation code that appears on the claim will be shown.
7. **Medical Record Number**: provider's internal financial number for a patient.
8. **Days or Visits**: Number of days or visits allowed.
9. **Total Charges**: Corresponds to the gross amount billed on the claim.
10. **Non-covered**: Total of non-allowed charges.
11. **Payable Charges**: Allowable amount for the line item billed (total charges less non-covered charges).
12. **Rate**: Reimbursement rate will be shown as a percentage of payable charges. (Optional)
13. **Paid Amount**: Amount paid. When reconciling the amount paid to the warrant amount, add the line amounts, not the claim summary amount. Payment appears on the warrant on the same page where the line amount appears.
14. **RAD Code**: Denial code that appears beside each claim line billed.
15. **RAD Message**: Code and abbreviated message appear on the first line. If the claim is an adjustment or a denial due to duplicate billing, the warrant number of the original claim appears on the second line.
16. **Denial Codes and Messages**: Denial codes with their full explanation appear at the bottom of the RAD under a summary header.
17. **Other Health Coverage Billing Message**: This includes the name and address of the recipient's insurance carrier and the policyholder's SSN. This information is included on the RAD when the claim has been denied because proof of Other Health Coverage billing was required and did not accompany the claim. (RAD code 657 is used to indicate this denial.) (Optional)
18. **Provider Number**: A National Provider Identifier (NPI).
19. **Claim Type**: The type of claim submitted for reimbursement.
20. **Page**: Number of pages of the RAD.
21. **Patient Liability/Other Coverage**: A patient's copay, coinsurance, Share of Cost or Other Health Coverage.

The ICF/DD Home living arrangement is a Medi-Cal Covered Service offered to individuals with intellectual and developmental disabilities who are eligible for services and support through the Regional Center service system. The Lanterman Developmental Disabilities Services Act (Lanterman Act) provides an entitlement to services and support for individuals with intellectual and developmental disabilities and their families. Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Homes, Intermediate Care Facilities for the Developmentally Disabled Habilitative (ICF/DD-H) Homes,

and Intermediate Care Facilities for the Developmentally Disabled Nursing (ICF/DD-N) Homes. The ICF/DD benefit is covered by Medi-Cal and offered to Individuals with Developmental Disabilities (IDD) who are eligible for services and support through the Regional Center system.

The Lanterman Act outlines (1) The rights of individuals with developmental disabilities and their families, (2) How the Regional Centers and service providers can help these individuals, (3) What services and supports individuals and family members can obtain, (4) How to use the Individualized Program Plan (IPP) to get needed services, (5) Additional important information and rights. California's Regional Center delivery system established under the Lanterman Act provides lifelong services and support to assist those served to lead the most independent and productive lives in their chosen communities. Required functions of the Regional Center system include intake, assessment, eligibility determination, person-centered planning, case management, and the purchase of necessary services and supports for eligible individuals.

ICF/DD facilities and Homes are not Medicare providers, and the per diem is not Medicare eligible. For Members who are dually Medicare and Medi-Cal covered, or who have OHC, Anthem will coordinate care and address coverage needs, regardless of payor source. Anthem will ensure that the ICF/DD Home and their network providers have appropriate training on benefits coordination, including balanced billing prohibitions. Day Program and related transportation (referenced in the ICF-DD State Plan Amendment19) will continue to be provided by ICF/DD-N Homes and are not the responsibility of Anthem.

Because it is Regional Centers' duty to ensure their members residing in ICF/DD Homes receive all services and supports identified in the IPPs. Anthem will inform Regional Centers of which services will be provided by Anthem. A Memorandum of Understanding between Regional Centers and Anthem that includes coordination for ICF/DD Members will support this coordination effort.

Share of Cost

Anthem processes claims submitted by ICF/DD Homes consistent with Medi-Cal guidelines for Share of Cost (SOC). The ICF/DD Home will subtract the SOC payment collect or obligated from the claim amount and submit the claim to Anthem to pay the balance.

Long-term Care and Skilled Nursing Facilities

Long-Term Care (LTC) is the provision of care in a facility, such as a skilled nursing facility or sub-acute facility for an extended period (in other words, longer than the month of admission plus one month). Long term subacute care is the responsibility of the health plan for all active counties effective January 1, 2024.

LTC services are primarily for the purpose of assisting the member with their activities of daily living or in meeting personal rather than medical needs. LTC does not include specific therapy for an illness or injury, is not skilled care, and does not require the continuing attention or supervision of trained, medical, or paramedical personnel.

LTC Eligibility Referral Process

LTC services are available to Medi-Cal recipients who require 24-hour long or short-term care and have a written order from their PCP requesting the services.

Requests for LTC authorizations should be submitted prior to the first day of service and no later than 30 days past the first day of service. General guidelines for obtaining a prior authorization (PA) for LTC services are as follows:

- Requests for authorizations must include a completed LTC authorization request form, a Medication Administration Record (MAR) and the most recent Minimum Data Set (MDS) for the member.
- Effective May 1, 2023, a Preadmission Screening and Resident Review (PASRR) must be included as part of authorization requests. For more information, visit dhcs.ca.gov/services/mental-health-services-division-default/preadmission-screening-and-resident-review.
- Requests for authorizations may be made through the provider website (preferred) or via fax.
- Facilities who have multiple members needing authorization for LTC services should submit each request separately.

PA requests may be faxed to:

Location	Phone
Southern California	877-279-2482
Northern California	844-285-1167
Central California	866-639-2281

An LTSS service coordinator will review the request and determine if the member qualifies for LTC placement following clinical guidelines established by DHCS.

LTSS Liaisons

Members and providers may request assistance from an LTSS Liaison. Liaisons are trained Anthem associates who understand the full spectrum of LTSS, home- and community-based services, and long-term institutional care, including payment and coverage rules. Liaisons can help facilitate member care transitions and be engaged in the Interdisciplinary Care Team meetings as appropriate. Providers and members may request an LTSS Liaison by contacting Customer Care.

LTC Claims and Reimbursement

PAs are required for all LTC services. Providers rendering LTC services should submit claims to Anthem using the appropriate revenue and accommodation codes.

There are several nuances specific to LTC that should be taken into consideration when navigating the LTC billing and payment process. This includes retroactive eligibility, authorizations for LTC absences, member share of cost, and the relationship between LTC and hospice.

Retroactive Eligibility

Anthem understands the unique requirements of LTC facilities to accept residents as Medi-Cal pending. As soon as the facility receives notice from the state of the Medi-Cal approval, the facility should verify eligibility on the Anthem website and then request an authorization back to the date of eligibility as established by the state. Anthem requests this to be submitted within 30 days of the change in eligibility.

Note: It may take the state 24 to 48 hours to transmit an updated eligibility file to Anthem.

Authorized LTC Absences

LTC facilities are allowed to request a bed hold for up to seven days when an LTC member leaves a facility and is admitted to an acute care facility or hospital. To ensure accurate payment, the facility must bill hospital leave days consecutively beginning with the date of admission. If a member goes to a hospital for observation purposes and is not admitted, the LTC facility should bill for this as a normal day of service.

In the event of a nonmedical absence from an LTC facility, providers must obtain an authorization and bill utilizing the appropriate end hold/leave of absence revenue code and accommodation code. A maximum of 18 home leave days for LTC are allowed per calendar year (certain exceptions may apply).

Anthem will cover the stay when Members transfer from an ICF/DD Home to any acute care hospital setting, a post-acute care setting such as a skilled nursing facility (SNF), or a rehabilitation facility, and then require a return to an ICF/DD Home. According to these regulations. Anthem will authorize up to 73 days per calendar year for an LOA. A physician signature is required for an LOA only when a member is participating in a summer camp for the developmentally disabled. For a bed hold, Anthem must authorize up to a total of seven calendar days per hospitalization. The ICF/DD Home shall hold a bed vacant during the entire hold period – a maximum of seven days for each bed hold period – but is not required to hold the bed if notified in writing by the attending physician that the patient require more than seven days of hospitalization.

Providers will not be reimbursed for days a bed is held for a resident beyond the limits set forth above and will not be reimbursed for any absences without preauthorization.

Member Financial Liability/Share of Cost

For members who have a Medi-Cal share of cost (SOC), the LTC facility is responsible for collecting the SOC amount each month and must represent the liability in **box 39** on each claim submitted. The SOC should be indicated by billing value code 23 with amount collected on the claim. The payment remitted by Anthem will be reduced by the member liability amount.

The following examples are provided to assist LTC facilities with addressing member SOC.

Example 1: The member is approved for LTC as of the 1st of the month, remains in the facility for the entire month, and has a $1,000 Medi-Cal SOC.

- The state issues a notice of action for the month for the amount of $1,000
- The facility per diem is $150: 150 x 30 = $4,500
- The facility collects the $1,000 patient liability and submits a claim to Anthem representing the collected amount in box 39
- Anthem will make a payment to the facility in the amount of $3,500

Example 2: The member is approved for LTC as of the 15th of the month, remains in the facility through the end of the month, and has a $1,000 Medi-Cal SOC (of which, $400 has been met).

- The state issues a notice of action for the month for the amount of $600 and for the following month forward of $1,000 per month
- The facility collects the $600 patient liability and submits a claim to Anthem representing the collected amount in box 39
- The facility per diem is $150: 150 x 15 = $2,250
- Anthem will make a payment to the facility in the amount of $1,650
- The facility will collect $1,000 from the patient in the following month

Example 3: The member is approved for LTC as of the 1st of the month and has a $1,000 Medi-Cal SOC. However, the member is discharged on the 6th day of the month.

- The state issues notice of action for the month for the amount of $1000
- The facility per diem is $150 and the facility collects the $1000 patient liability on the first of the month
- The member is discharged on day 6: 6 x $150 = $900
- The facility refunds $100 to the member/family or estate and submits a claim to Anthem representing the $900 collected in box 39
- Anthem will make a payment to the facility in the amount of $0

Hospice

Per APL 25-008, Anthem does not require a prior authorization for room and board payments for members receiving hospice services in skilled nursing facilities (SNF) or intermediate care facilities (ICF).

For all our members that are dual eligible, Medicare remains the primary payor for hospice care, Anthem Medi-Cal will cover cost sharing for contracted services.

Community-based Adult Services

Community-Based Adult Services (CBAS) is a facility-based outpatient day health program serving individuals 18 years of age or older that puts them at risk for institutional care.

Enrolled members attend an Anthem-contracted adult day healthcare center several times a week where they can receive (among other services):

- Skilled nursing Social services
- Physical, occupational and speech therapies
- Personal care
- Family/caregiver training and support
- Hot meals and nutritional counseling
- Behavioral health services
- Transportation (to/from the center to residence)

The primary objective of CBAS is to delay or prevent institutionalization and maintain individuals in their homes and communities for as long as possible. CBAS stresses partnership with the member, the family and/or caregiver, and the PCP in working toward maintaining personal independence.

Each CBAS center has a multidisciplinary team of health professionals who conduct a comprehensive assessment of potential participants and work with the member to meet their specific health and social needs.

CBAS Eligibility and Referral Process

CBAS services may be provided to members 18 years of age or older who:

- Meet nursing facility A or B requirements
- Have organic/acquired or traumatic brain injury and/or chronic mental health conditions
- Have Alzheimer's disease or other dementia
- Have mild cognitive impairment
- Have a developmental disability

Referrals or requests for CBAS can be made by the member, their caregiver, a family member, a nurse practitioner or a PCP. Preauthorization is required for both initiating and renewing CBAS services. Anthem does not require prior authorization for face to face assessments, consistent with DHCS guidelines. Referrals should be faxed to Anthem at:

County	Phone
L.A. County	**855-336-4042**
All Other Counties	**855-336-4041**

Requests for CBAS authorizations should be submitted no more than 30 calendar days before the start date and no later than one day prior.

Once the initial CBAS request is received, the following steps are taken:

1. An Anthem registered nurse will conduct an eligibility assessment of the member and assist in locating a CBAS facility if needed.
2. Using an evaluation tool developed and provided by the state, Anthem will approve or deny the request for services.
3. If approved, the member's selected CBAS center will conduct a needs assessment, develop a plan of care for the member, and determine the level of service that will be provided at the center.

Effective October 1, 2022, the provision of Emergency Remote Services (ERS) became a permanent and added component under the CBAS program. ERS provides CBAS services in a location other than the CBAS center. ERS services are only available to continuing participants with an existing CBAS CarePlan in place. All CBAS providers must offer ERS to participants when all the ERS criteria are met.

CBAS providers are required to notify Anthem of ERS within three business days after the start of ERS (10 business days if a public emergency) utilizing the referral form found on the provider website under Forms and Prior Authorization (CEIF (CDA 4000). CBAS providers are also required to notify when the member receiving ERS resumes receiving CBAS services at the facility.

For more information on CBAS, call California Department of Aging at **916-419-7500**.

For a complete list of CBAS centers and contact numbers, please go to the California Department of Aging website at aging.ca.gov/Providers_and_Partners/Community-Based_Adult_Services.

MSSP Eligibility and Referral Process

The MSSP program currently operates under a California 1915c HCBS (Home and Community Based Services) Waiver and there are a limited number of slots available for members. Eligibility and authorization of services is determined by MSSP providers based on criteria set by the state.

In general, to be eligible for MSSP services a member must:

- Be 65 years of age or older
- Live within an MSSP service area
- Be eligible for Medi-Cal
- Be certified for nursing home placement

An MLTSS care coordinator can assist the member with locating an MSSP provider and navigating the application process. For members who are placed on an MSSP's waiting list, the coordinator will work with the MSSP provider and other HCBS providers to address the member's needs until they can be enrolled in the program.

Members who may benefit from MSSP or need assistance navigating the program can contact an Anthem MLTSS Service Coordinator at **855-871-4899**.

Members may also self-refer and apply directly with the MSSP providers determined by the members county of residence. See aging.ca.gov/Providers_and_Partners/Multipurpose_Senior_Services_Program.

Enhanced Care Management

Enhanced Care Management (ECM) is a statewide benefit established by the Department of Health Care Services (DHCS) to provide a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal beneficiaries enrolled in Medi-Cal managed care. Enhanced Care Management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to DHCS defined populations of focus. ECM is an opt-in program for members. A member may change ECM providers at any time.

ECM is delivered exclusively by community-based providers who are uniquely qualified to identify and engage eligible members. ECM is primarily an in-person program, which makes the program particularly suited to high-risk members who are hard to engage and support telephonically.

The Medi-Cal ECM benefit, designed by the Department of Health Care Services (DHCS) and authorized by the Centers for Medicare and Medicaid Services (CMS), provides seven core services primarily through in-person contact:

1. Outreach and engagement
2. Comprehensive assessment and care management plan
3. Enhanced care coordination
4. Health promotion
5. Comprehensive transitional care
6. Member and family supports
7. Coordination of and referral to community and social support services

The overall goal of the ECM benefit is to provide comprehensive care and achieve better health outcomes for the highest need beneficiaries in Medi-Cal.

Eligibility

The Department of Healthcare Services (DHCS) has defined the following populations of focus (PoFs) for ECM:

Population	Description
Individual experiencing homelessness	Adults (whether or not the dependent children/youth living with them) who are experiencing homelessness and have at least one complex physical, behavioral, or developmental health need with inability to successfully self-manage. Children, youth, and families, including unaccompanied children/youth, who are experiencing homelessness or are sharing the housing of other persons.3
Individuals at risk for avoidable hospitalization or emergency department (ED) utilization	Adults who have five or more preventable emergency room visits; or three or more unplanned hospital, or short-term skilled nursing facility (SNF)

3 Children, youth, and families do not need to meet the additional "complex, physical, behavioral, or developmental need" criteria for adults.

Population	Description
	stays, in a six-month period within the last 12 months. Children and youth who have three or more emergency room visits or two or more unplanned hospital or short-term SNF stays within the last 12 months.
Individuals with serious mental health and/or substance use disorder (SUD) needs:	Adults who meet the eligibility criteria for participation in, or obtaining services through, Specialty Mental Health Services (SMHS), The Drug Medi-Cal Organization Delivery System (DMC-ODS) or the Drug Medi-Cal (DMC) program, are actively experiencing at least one complex social factor, and meet one or more of the following criteria: • High risk for institutionalization. • User of crisis services. • Two or more emergency department visits or inpatient in past 12 months due to SMI/SUD-related hospitalizations, or pregnancy. Children and youth who meet the eligibility criteria for participation in or obtaining services through SMHS and DMC-ODS or DMC program
Adults living in the community and at risk for LTC institutionalization:	Adults who are at risk for long-term care (LTC) institutionalization and in the absence of services and supports, would otherwise require care for 90 consecutive days or more in an inpatient NF.
Adult nursing facility (NF) residents transitioning to the community	• Adults who are NF residents who want and, with support, are able to transition to the community.
Individuals transitioning from incarceration	Adults who are transitioning or have transitioned from a correctional setting within the last 12 months and have a mental illness, chronic condition, SUD, intellectual or developmental disability, traumatic brain injury (TBI), HIV/AIDS, or pregnancy. Children and youth who are transitioning or transitioned from a youth correctional facility within the past 12 months[4].
Children and youth enrolled in California Children's Services (CCS)	• Children and youth who are enrolled in CCS and are experiencing at least one complex social factor influencing their health.[5]
Children and youth involved in child welfare:	Children and youth who are:

4 Children and youth do not need to meet the additional health need criteria noted for adults.

5 The presence of a complex social factor is not necessary for children in CCS to be eligible for ECM if they meet the criteria of any other ECM PoF.

Population	Description
	• Under age 21 and are receiving foster care in California. • Under age 21 and previously received foster care in California or another state within the last 12 months. • Have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state. • Under age 18 and are eligible for or in California's Adoption Assistance Program. • Are under age 18 and are receiving or have received services from California's Family Maintenance program within the last 12 months.
Birth Equity	Adults and youth who are pregnant or are postpartum (through 12 months) and are subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality, including Black, American Indian, and Alaska Native, and Pacific Islander pregnant and postpartum individuals.

Anthem uses the following methods to identify ECM-eligible members:

- Member self-referrals to ECM provider or directly to Anthem
- Referrals from other Anthem care management staff, Anthem network providers, and community organizations
- ECM provider referrals to Anthem of potentially eligible members identified at the point of care
- Data-driven: Anthem identifies members who may meet DHCS's eligibility requirements using claims and other available data.

Referral Process

Providers may submit potentially eligible members through the Availity Essentials platform (preferred). The referral form can also be submitted via secure email to calaimreferrals@anthem.com or faxed to **877-734-1854** if the provider is unable to access through Availity Essentials. Non-ECM providers can also submit their referrals via National Call Center:

Location	Phone
Los Angeles	888-285-7801
Outside of Los Angeles	**800-407-4627**

Anthem may request supporting documentation from referring entities (ECM and non-ECM providers, members, other organizations) to assist in the eligibility determination for members who are identified as potentially eligible for ECM. The Enhanced Care Management Member Referral Forms for referring entities to complete and submit may be found at providers.anthem.com/california-provider/patient-care > **Patient Care** > **CalAIM**.

ECM providers can find webinar recordings, mandatory trainings, ECM Claims Guidance and other frequently-used CalAIM documents and resources using their Elsevier Performance Manager Account. To request access, follow this link.

Community Supports

Community Supports are voluntary, flexible wrap-around services or settings provided by Anthem and integrated into its population health management. The services are provided as a substitute for utilization of other services or settings such as a hospital or skilled nursing facility admission, discharge delays, or emergency department use. Community Supports are integrated with care management for members at medium to high level risk and fill gaps in state plan benefits to address medical or other needs that may arise from social determinants of health.

Community Supports are available in all counties, dependent on provider availability, in which Anthem operates to all eligible members who reside in those counties. Community Supports are optional for members and include the following distinct services or settings. For a county-by-county breakdown, visit CalAIM Community Supports – Managed Care Plan Elections.

Community Supports	Description
Housing Transition Navigation Services	Assists members with obtaining housing (does not include room and board) based on an individualized housing support plan.
Housing Deposits	Assists members with identifying, coordinating, securing, or funding one-time services and household items necessary to enable the member to establish a basic household that does not constitute room and board.
Housing Tenancy and Sustaining Services	Assists members with the provision of tenancy and sustaining services with the goal of maintaining safe and stable tenancy once housing is secured.
Short-term Post Hospitalization Housing (STPH)	Provides members with housing and ongoing support necessary for recuperation and recovery. STPH is for members who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their recovery after exiting an inpatient hospital, residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care.
Recuperative Care (Medical Respite)	Short-term residential care for members who no longer require hospitalization but still need time to heal from an injury or illness and would be exacerbated by an unstable living environment. Members will have access to primary care, behavioral health services, case management and supportive social services. Services includes interim housing with bed and meals and ongoing monitoring of the member's health condition.

Community Supports	Description
Respite Services	Services provided to caregivers of members who require intermittent temporary supervision. Services are provided on a short-term basis because of absence of need for relief of the persons that normally care for and/or supervise the member and are non-medical in nature. This is rest for unpaid caregivers only. Services provided in the home or a facility.
Day Habilitation	Programs designed for members to assist in acquiring, retaining and improving self-help, socialization, and adaptive skills necessary to reside successfully in the member's natural environment.
Assisted Living Facility Transition (formerly known as Nursing Facility Transition/Diversion to Assisted Living Facilities such as Residential Care Facilities for the Elderly and Adult Residential Facilities)	Assists members who live in the community and want to avoid institutionalization by transitioning to an assisted living facility. Service also assists members residing in a Nursing facility to transition to an assisted living facility. Service includes non-room and board costs.
Community or Home Transition Services (formerly known as Community Transition Services/Nursing Facility Transition to a Home)	Services to help members transitioning from a nursing facility to the community with non-recurring set-up expenses.
Personal Care and Homemaker Services	Provides members who need assistance with Activities of Daily Living and Instrumental Activities of Daily Living with personal care and homemaker services above and beyond In Home Supportive Services (IHSS) hours, during waiting periods for IHSS, as well as to assist with avoidance of short-term skilled nursing facility stays.
Environmental Accessibility Adaptations (Home Modifications)	Home modifications that are necessary to ensure the health, welfare and safety of the member or enable the member to function with greater independence in their home. Without such adaptations, the member would require institutionalization.
Meals/Medically Tailored Meals	Meals delivered to the member's home immediately following discharge from a hospital or nursing home or that meet the unique dietary needs of members with chronic illnesses. May also include medically supportive food and nutrition services, such as medically tailored groceries and healthy food vouchers.
Sobering Centers	An alternative destination for members who are found to be publicly intoxicated due to alcohol or other drugs and would otherwise be transported to the emergency department or jail.
Asthma Remediation	Physical modifications to the member's home environment necessary to ensure the health, welfare and safety of the member or enable the member to function in their home and without

Community Supports	Description
	which acute asthma episodes could result in the need for emergency services or hospitalization.
Transitional Rent	Up to six months of rental assistance in interim and permanent settings to members who are experiencing or at risk of homelessness, have certain clinical risk factors, and have either recently undergone a critical life transition (such as exiting an institutional or carceral setting or foster care), or who meet other specified eligibility criteria.

Eligibility and Limitations

Members may be eligible for one or more Community Supports based on eligibility and limitations established by DHCS as follows below.

Community Supports	Description
Housing Transition Navigation Services	Members who are homeless, at risk of homelessness or chronically homeless.
Housing Deposits	Members who are homeless, at risk of homelessness or chronically homeless. Limited to once per demonstration period, maximum of $7,500.
Housing Tenancy and Sustaining Services	Members who are homeless, at risk of homelessness or chronically homeless.
Short-term Post Hospitalization Housing	Members who are exiting Recuperative Care, inpatient hospital stays, residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, or nursing facility and are considered homeless, at risk of homelessness or chronically homeless. Duration subject to the Global Cap of 182 days across Recuperative Care and Short-term Post-Hospitalization Housing per 12 month rolling period and Transitional Rent once per 5-year demonstration period.
Recuperative Care (Medical Respite)	Members at risk for hospitalization or are post-hospitalization and who live alone with no formal supports, have housing insecurity or housing that would jeopardize their health and safety. Duration subject to the Global Cap of 182 days across Recuperative Care and Short-term Post-Hospitalization Housing per 12 month rolling period and Transitional Rent once per 5-year demonstration period.
Respite Services	For members living in the community and dependent on caregivers for most of their support to assist with Activities of Daily Living. Members without these caregivers would most likely be institutionalized. Direct care may not exceed 24

Community Supports	Description
	hours per day. Service limited to 336 hours per calendar year.
Day Habilitation	Members who are homeless, exited homelessness and entered housing in the past 24 months, at risk of homelessness, or institutionalized whose housing stability could be improved through participation in programs.
Assisted Living Facility Transition (formerly known as Nursing Facility Transition/Diversion to Assisted Living Facilities such as Residential Care Facilities for the Elderly and Adult Residential Facilities)	Member must be willing and able to live in an assisted living facility as well as meet the minimum necessary criteria for nursing facility level of care. Members must have resided in the facility for at least 60 days and willing and able to live in an assisted living facility. Members are directly responsible for paying their own living expenses, room, and board.
Community or Home Transition Services (formerly known as Community Transition Services/Nursing Facility Transition to a Home)	Members must be currently receiving care in a nursing facility for at least 60 days and choose to transition back to the community. Members must be able to safely reside in a home with appropriate and cost-effective supports and services. Limited to lifetime maximum of $7,500.
Personal Care and Homemaker Services	Members at risk of hospitalization or nursing facility institutionalization, members with functional deficits without adequate support systems or members who are IHSS eligible. Care may not exceed 24 hours per day. Limited to 60 days if not eligible for IHSS.
Environmental Accessibility Adaptations (Home Modifications)	Members at risk for institutionalization who have a home that is owned, rented, leased, or occupied by the member. Limited to a lifetime maximum of $7,500.
Meals/Medically Tailored Meals	Members with nutrition-sensitive conditions. Initial authorization limited to two meals per day and/or 1 box/voucher per week for 12 weeks. Reauthorizations based on medical necessity. This service not to solely address food insecurity.
Sobering Centers	Members who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from medical distress, and who would otherwise be transported to the emergency department or a jail and are appropriate to divert to a Sobering Center. Members are primarily homeless, have unstable living situations with a safe, supportive environment to become sober. Limited to a 24 hour stay per occurrence.
Asthma Remediation	Members with poorly controlled asthma (emergency room visit or hospitalization, or (2) sick/urgent care visits in the past (12) months, or a score of 19 or lower on the Asthma Control Test. A licensed care provider must provide

Community Supports	Description
	documentation that the service would likely avoid asthma-related hospitalizations, emergency department visits or other high-cost services. Limited to a lifetime maximum of $7,500.
Transitional Rent	Members who are experiencing or at risk of homelessness, have certain clinical risk factors, and have either recently undergone a critical life transition (such as exiting an institutional or carceral setting or foster care), or who meet other specified eligibility criteria.

Members may be identified as potentially eligible for Community Supports using multiple methods:

- ECM provider referrals to Anthem identified at the point of care
- Referrals from other Anthem staff, providers or Community Organizations
- Member self-referral to ECM provider or Anthem due to receiving information about Community Supports through member-facing materials
- Community based referrals from social determinants of health community resource links

Referral Process

Providers may submit potentially eligible members through the Availity Essentials platform (preferred). The referral form can also be submitted via secure email to calaimreferrals@anthem.com or faxed to **877-734-1857** if the provider is unable to access through Availity Essentials. Non-ECM providers can also submit their referrals via the Medi-Cal Customer Care Center:

Location	Phone
Los Angeles	**888-285-7801**
Outside of Los Angeles	**800-407-4627**

Anthem may request supporting documentations from referring entities (ECM providers, other providers, members, or organizations) to assist with the eligibility determination for members who are identified as potentially eligible for Community Supports. The referral form for referring entities to complete and submit can be found at providers.anthem.com/california-provider/patient-care/calaim > **Resources**.

CS providers can find webinar recordings, mandatory trainings, CS Claims Guidance and other frequently-used CalAIM documents and resources using their Elsevier Account. To request access please follow this link.

Street Medicine

As defined in the DHCS APL 24-001, Street Medicine refers to a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment. Street Medicine offers an opportunity to provide those needed services to Anthem Members by utilizing a whole person, patient centered approach to provide medically necessary health care and social services including housing supports. Street Medicine services are meant to be a harm reduction tool and critical to reducing Emergency Department visits and hospitalization.

Although an integral component of care for the homeless population of focus, health care services provided in shelter settings or mobile units/recreational vehicles (RV) that require Members to visit a fixed, specified location do not qualify as Street Medicine. Mobile units/RV's that go to the individual experiencing unsheltered homelessness in their lived environment ("on the street") is considered Street Medicine.

Street Medicine Provider Requirements

A Street Medicine provider refers to a licensed medical provider (for example, Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), Nurse Practitioner (NP), Certified Nurse Midwife (CNM)) who conducts patient visits outside of the four walls of clinics or hospitals and directly on the street, in environments where unsheltered individuals may be (such as those living in a car, RV, abandoned building, encampments, or other outdoor areas).

Direct Contracting with Street Medicine Providers

Anthem may cover the provision of medical services for members experiencing unsheltered homelessness through a direct contract with street medicine providers as a primary care provider, or a supplemental provider. The street medicine provider will be subject to Anthem administrative processes (for example, billing protocols, credentialing requirements, authorization guidelines) Under contract arrangement, both primary care provider and supplemental provider will have access to refer members to medically necessary covered services within the Anthem network. For a non-physician medical practitioner, Anthem will ensure compliance with state law and Contract requirements regarding physician supervision of non-physician medical practitioners.

Street Medicine – Primary Care Provider

A street medicine primary care provider is a licensed medical provider. Contracted street medicine providers may choose to serve as the member's assigned PCP upon member election. When elected by Members to act as their assigned PCP, the street medicine provider is responsible for providing the full array of primary care services.

Street Medicine – Supplemental Provider

The contracted Street Medicine provider has the right to decline the additional responsibilities of an assigned PCP, and instead, care for Members in a non-PCP capacity as a supplemental provider. A supplemental provider is a licensed medical provider. To provide care in this capacity, Supplemental street medicine providers must have processes in place to work with Anthem and member's PCP to ensure the member has referrals to primary care, Enhanced Care Management, Community Supports,

behavioral health services, and other social services as needed. Anthem will ensure appropriate referral and authorization mechanisms in place to facilitate access for supplemental providers to refer members to medically necessary covered services.

Prior Authorization

Prior authorization for members to see a street medicine provider is not needed if the member seeks services directly from a street medicine provider related to the member's primary care. For contracted street medicine providers that meet all the Anthem administrative processes, street medicine services can be provided to an eligible Anthem member and receive payment for these services, even if the member is assigned to a subcontractor, such as a PMG/IPA.

Street Medicine Provider Billing and Reimbursement

Street medicine providers are required to verify Anthem eligibility of individuals they encounter in the provision of healthcare services. Services rendered to members experiencing unsheltered homelessness, in their lived environment, will be paid at the relevant contracted rates under CMS Place of Service 27. Street medicine providers must comply with the billing provisions for street medicine providers as applicable in FFS, including but not limited to the Medi-Cal provider manual.

Anthem is responsible for ensuring non-duplication of services provided by any other covered benefit, program, and/or delivery system. If a street medicine provider is also contracted to provide other services in a separate contract, the street medicine contract will function independently from the other contracts. street medicine services, and only these services, will be billed using the street medicine direct contracting agreement and the appropriate Place of Service code 27.

Provider Data Sharing, Reporting and Administrative Requirements

Anthem contracted street medicine providers must comply with all applicable Anthem data sharing and reporting requirements in accordance with federal and state laws and the Anthem contract based on the provider contracting type.

Palliative Care Program

Anthem Palliative Care Program is a patient and family-centered care program that optimizes quality of life for adult members with a serious illness. Palliative Care includes coordination of services throughout the continuum of illness to address physical, intellectual, emotional, social, and spiritual needs, and to facilitate member autonomy, access to information, and choice. Unlike the hospice benefit, members can receive palliative care services concurrently with curative care.

Types of Services

Anthem contracts with Carelon Palliative Care to deliver services, such as:

- Advanced Care Planning
- Care Coordination
- Mental Health and Medical Social Services
- Pain and Symptom Management
- Care Plan Development
- Palliative Care Assessment and Consultation

Palliative Care Eligibility and Referral Process

In order to qualify for Anthem adult Palliative Care, members must meet all general eligibility criteria and at least one of the disease-specific criteria listed below.

General eligibility criteria:

- Patient is likely or has started to use the hospital or emergency department to manage their late-stage disease ("unanticipated decompensation").
- Patient is in the late stage of illness.
- Patient's death within a year would not be unexpected.
- Patient has received appropriate medical therapy.
- Patient and designated support person agree to attempt in-home, residential-based or outpatient disease management and are willing to participate in advanced care planning.

Disease-specific criteria:

- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- Advanced cancer
- Liver disease

Referral Process

To initiate a referral for Palliative Care, email Palliative Care at anthempalliativecareprogram@anthem.com.

Additional information on Palliative Care Services please reference All Plan Letter 18-020 or visit the DHCS website at dhcs.ca.gov/providers-partners/palliative-care-policies.

Pediatric Palliative Care

Pediatric Palliative Care is available to Anthem members as a part of DHCS's Palliative Care Waiver is specialized care for children (members under 21 years of age) with serious, long-term health conditions. A member may be eligible for palliative care and hospice services concurrently.

Anthem is contracted with providers in San Francisco, Santa Clara, and Los Angeles counties to provide Home-based services that align with the previous waiver including:

- All adult services (see listed in Palliative Care Program)
- Specialized services:
  - Expressive therapy (creative art, music, massage, and child life)
  - Family Bereavement counseling for family and other primary caregivers as applicable
  - Respite care
  - 24/7 nursing hotline

Children residing outside of the counties listed above are able to access our standard palliative care network and services.

In order to qualify for Palliative Care, members must have one of the eligible conditions:

- Conditions for which curative treatment is possible, but may fail (for example, advanced cancer)
- Conditions requiring intensive long-term treatment aimed at maintaining quality of life (for example, HIV, cystic fibrosis)
- Progressive conditions for which treatment is exclusively palliative after diagnosis (for example, progressive metabolic disorders)
- Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications (for example, extreme prematurity)

For more information on the Pediatric Palliative Care Program, including eligibility criteria, referral processes, and coordinating with providers, please contact Pediatric Palliative Care Program team at anthempalliativecareprogram@anthem.com.

Additional information can be found on the DHCS website at dhcs.ca.gov/services/partners-for-children.

Community Health Worker

Community Health Workers (CHW) services are preventive health services and considered a Medi-Cal benefit as of July 1, 2022. CHW services delivered by a CHW are to prevent disease, disability and other health conditions or their progression; to prolong life; and to promote physical and mental health. CHWs may include individuals known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals.

Supervising CHW providers employ and oversee the CHW, ensure services are delivered to members, and submit claims for services provided by CHWs. The supervising CHW provider must be a licensed provider, a hospital, an outpatient clinic, a local health jurisdiction, or a community-based organization.

Referrals and Eligibility

No prior authorization required for the first 12 units of service, but a written recommendation that ensures medical eligibility must be submitted to Anthem prior to the submission of any claims. Refer to the California Advancing and Innovating Medi-Cal (CalAIM) page of our provider website for information on how to submit.

Written recommendations with medical eligibility can be made by a physician or other licensed practitioner of the healing arts within the scope of their practice by state law. The required recommendation can be provided by a written recommendation placed in the member's record or a standing recommendation. For CHW services rendered in the emergency department, the treating provider may verbally recommend CHWs to initiate services and later document the recommendation in the member's medical record of the Emergency Department Visit. The recommending licensed provider does not need to be enrolled in Medi-Cal or be a network provider within Anthem. Other licensed providers within their scope of practice include:

- Clinical Nurse Specialist
- Dentists
- Licensed Clinical Social Workers
- Licensed Educational Psychologists
- Licensed Marriage & Family Therapists
- Licensed Midwives
- Licensed Professional Clinical Counselors
- Licensed Vocational Nurses
- Nurse Midwives
- Nurse Practitioner
- Pharmacists
- Physician Associate
- Podiatrist
- Licensed Psychologists
- Public Health Nurses
- Registered Dental Hygienists
- Registered Nurses

CHW services are considered medically necessary for Members with one or more chronic health conditions (including behavioral health) or exposure to violence and trauma, who are at risk for a chronic health condition or environmental health exposure, who face barriers in meeting their health or health-related social needs, and/or who would benefit from preventive services.

The recommending provider must determine eligibility based on the presence of one or more of the following:

- Diagnosis of one or more chronic health (including behavioral health) conditions, or a suspected mental disorder or substance use disorder that has not yet been diagnosed.
- Presence of medical indicators of rising risk of chronic disease (for example, elevated blood pressure, elevated blood glucose levels, elevated blood lead levels or childhood lead exposure) that indicate risk but do not yet warrant diagnosis of a chronic condition.
- Any stressful life event presented via the Adverse Childhood Events (ACE) screening.
- Presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse.
- Results of a social drivers of health (SDOH) screening indicating unmet health-related social needs, such as housing or food insecurity.
- One or more visits to a hospital Emergency Department (ED) within the previous six months.
- One or more hospital inpatient stays, including stays at a psychiatric facility, within the previous six months, or being at risk of institutionalization.
- One or more stays at a detox facility within the previous year.
- Two or more missed medical appointments within the previous six months.
- Member expressed need for support in health system navigation or resource coordination services.
- Need for recommended preventive services, including updated immunizations, annual dental visit, and well childcare visits for children.

CHW violence prevention services are available to members who meet any of the following circumstances as determined by a licensed practitioner:

- Member has been violently injured as a result of community violence.
- Member is at significant risk of experiencing violent injury as a result of community violence.
- Member has experienced chronic exposure to community violence.

CHW violence prevention services are specific to community violence (for example, gang violence). CHW services can be provided to Members for interpersonal/domestic violence through the other pathways with training/experience specific to those needs.

Asthma prevention services are available to members with poorly controlled asthma as defined as:

- Having a score of 19 or lower on the Asthma Control Test, or
- An asthma-related emergency department visit or hospitalization or two instances of sick or urgent care asthma-related visits in the past 12 months

Members must not be receiving duplicative services through Enhanced Care Management or other waiver programs. Information on enrollment in ECM can be viewed on the provider website. To ensure non-duplication, all submitted recommendations will be reviewed for potential duplicate programs and services. The CHW supervising provider will be contacted immediately should potential duplicative programs and services are identified.

A written recommendation for CHW services authorizes 12 units of the following in a year:

- Health education to promote health or address barriers to healthcare, including providing information or instruction on health topics. This may include coaching and goal setting to improve a beneficiary's health or ability to self-manage health conditions.
- Health navigation to provide information, training, referrals, or support to assist Members to access healthcare, understand the healthcare delivery system, or engage in their own care. This includes connecting Members to community resources necessary to promote health; address barriers to care, including connecting to medical translation/interpretation or transportation services; or address health-related social needs.
- Screening and assessment services (that do not require a license) to identify the need for services and connect Members to appropriate services to improve their health.
- Individual support or advocacy to prevent the onset or exacerbation of a health condition or prevent injury or violence. This includes peer support as well if not duplicative of other covered benefits.

A written recommendation for asthma preventive services authorizes 8 units of asthma education and biannual in-home environmental trigger assessments in a year.

For members who need multiple ongoing CHW services or continued CHW services after 12 units of services (or 8 units for Asthma prevention services), a written recommendation and a care plan must be submitted. The care plan must be written by one or more licensed providers, which may include the recommending provider and other licensed providers affiliated with the CHW supervising provider. The care plan may not exceed a period of one year and must include:

- Specify the condition that the service is being ordered for and be relevant to the condition
- Include a list of other healthcare professionals providing treatment for the condition or barrier
- Contain written objectives that specifically address the recipient's condition or barrier affecting their health
- List the specific services required for meeting the written objectives
- Include the frequency and duration of CHW services (not to exceed the provider's order) to be provided to meet the plan's objectives

Supervising CHW providers must submit the written care plan and request for additional units to Anthem for review prior to the initiation of services beyond 12 units (or eight for Asthma prevention services). This does not apply to services rendered in the Emergency Department. For information on how to submit, refer to the provider website at providers.anthem.com/california-provider/patient-care/calaim.

Referrals may be submitted via fax or email utilizing the designated referral form.

Doula

Effective January 1, 2023, doula services became a statewide, covered, preventive service. Doulas are birth workers who provide health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth, including during miscarriage, stillbirth, and abortion.

Doula services can only be provided during pregnancy; labor and delivery, including stillbirth; miscarriage; abortion; and within one year of the end of a member's pregnancy. Doula services require a written recommendation by a physician or other licensed practitioner of the healing arts within the scope of their practice under the state law. The recommendation form used can be either the Anthem Doula Services Benefits Recommendation form or the DHCS Medi-Cal Doula Services Recommendation form. The criteria for this written recommendation for doula services would be met if the member is pregnant or was pregnant within the past year and would either benefit from doula services or they request doula services. Additionally, as an alternative way for members meeting criteria to access services, DHCS has issued a standing recommendation for doula services that fulfills the requirement for a written recommendation. This standing recommendation would authorize all the same services that an initial written recommendation would.

The initial recommendation can be provided through the written recommendation in the member's record, standing recommendation for doula services, or a standard form signed by the physician or practitioner that a member can provide to the doula.

Doula services can be provided virtually or in-person with locations in any setting.

An initial recommendation for doula services authorizes the following:

- One initial visit.
- Up to eight additional visits that can be provided in any combination of prenatal and postpartum visits.
- Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion, or miscarriage.
- Up to two extended three-hour postpartum visits after the end of a pregnancy.

An additional recommendation from a physician or other licensed practitioner of the healing arts acting within their scope of practice is required for up to nine additional postpartum visits. This recommendation can be noted in the member's medical record by the recommending licensed provider, or a member can ask a licensed provider to complete either the Anthem Doula Services Benefits Recommendation form or the DHCS Medi-Cal Doula Services Recommendation form. The standing recommendation from DHCS cannot be used for additional postpartum visits.

For additional information, including recommendation forms, refer to the Doula Program section at providers.anthem.com/california-provider/patient-care/calaim.

Chapter 8: Provider Procedures & Responsibilities

Responsibilities Applicable to All Providers

Our providers must fulfill their roles and responsibilities with the highest integrity. We lean on their extensive healthcare education, experience, and dedication to our members.

There are a number of responsibilities applicable to all Anthem providers including:

- After-hours services
- Eligibility verification
- Collaboration
- Confidentiality
- Continuity of care
- Licenses and certifications
- Mandatory reporting of abuse
- Medical records standards and documentation
- Office hours
- Open clinical dialog/affirmative statement
- Oversight of non-physician practitioners
- Prohibited activities
- Provider contract terminations
- Termination of ancillary provider/patient relationship
- Updating provider information
- Fully complying with all terms and conditions of the DHCS contract including ownership and control disclosures, audits and inspections of subcontractors, and monitoring activities related to care coordination, data reporting and other functions

Provider Orientation Training

All new Anthem Blue Cross Medi-Cal providers must complete the initial Provider Orientation (NPO) within 10 business days of onboarding and complete it within 30 working days.

Separately, all existing Anthem Blue Cross Medi-Cal providers are required to complete provider orientation training every two (2) years covering Medi-Cal Managed Care and other government-funded programs administered by the Medicaid Business unit. This training includes, but is not limited to, how to effectively use electronic systems to support timely submission of clean claims and equivalent encounters.

Anthem will routinely evaluate effectiveness of the training and make adjustments as needed.

Prohibited Activities

- Segregating members in any way from other persons receiving similar services, supplies, or equipment
- Discriminating against Anthem members or Medicaid participants

Note: Services should always be provided without regard to race, religion, sex, color, national origin, age, or physical/behavioral health status.

Balance Billing

Providers are prohibited from billing eligible members for covered services and billing dual eligible beneficiaries for Medicare cost sharing. Medi-Cal beneficiaries should not pay for physician visits and other medical care when they receive covered services from a provider in their provider network. This means beneficiaries cannot be charged for co-pays, co-insurance, or deductibles. This applies to both Medicare and Medi-Cal providers.

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 immediately directed to **dial 911** or to proceed directly to the nearest hospital emergency room.

If the PCP's staff or answering service is not immediately available, an answering machine may be used. The answering machine message must instruct members with emergency healthcare needs to dial **911** or go directly to the nearest hospital emergency room. The message must also give members an alternative contact number so they can reach the PCP or on-call provider with medical concerns or questions.

Network On-call Providers

Anthem prefers that our PCPs use network providers for on-call services. When that is not possible, the PCP must help ensure that the covering on-call physician or other professional provider abides by the terms of our provider contract.

Collaboration

Providers share the responsibility of giving respectful care and working collaboratively with Anthem specialists, hospitals, ancillary providers, and members and their families. Providers must permit members to participate actively in decisions regarding medical care including, except as limited by law, their decision to refuse treatment.

Mandatory Reporting of Child Abuse, Elder Abuse or Domestic Violence

Providers must ensure that office personnel have specific knowledge of local reporting requirements and procedures to make telephone and written reports of known or suspected cases of abuse.

All healthcare professionals must immediately report actual or suspected child abuse, elder abuse, or domestic violence to the local law enforcement agency by telephone. In addition, providers must submit a follow-up written report to the local law enforcement agency within the time frames as required by law.

Open Clinical Dialogue/Affirmative Statement

Nothing within the provider's Provider Agreement or this Provider Manual should be construed as encouraging providers to restrict medically necessary covered services or limit clinical dialogue between providers and their patients. Providers can communicate freely with members regarding the treatment options available to them including medication treatment options regardless of benefit coverage limitations.

Oversight of Non-physician Practitioners

All providers using nonphysician practitioners must provide supervision and oversight of such nonphysician practitioners consistent with state and federal laws. A provider shall not supervise more than four mid-levels at any one time. The supervising physician and the nonphysician practitioner must have written guidelines for adequate supervision, and all supervising providers must follow state licensing and certification requirements.

Nonphysician practitioners include the following categories:

- Advanced registered nurse practitioners
- Physician assistants

These nonphysician practitioners are licensed by the state and working under the supervision of a licensed physician as mandated by state and federal regulations.

Providers must notify Anthem promptly of any changes to the supervising physician.

Provider Rights

Anthem providers acting within the lawful scope of practice shall 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 treatment that may be self-administered
- 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 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 their license or certification under applicable law solely based on that license or certification

Anthem provider selection policies and procedures do not discriminate against particular providers who serve high-risk populations or specialize in conditions that require costly treatment.

Note: Anthem members may select any contracted PCP as their primary physician as long as that PCP is taking new patients. We furnish each PCP with a current list of assigned members and from time to time provide medical information about our members' potential healthcare needs. In this way, providers can more effectively provide care and coordinate services.

Hospital Scope of Responsibilities

PCPs refer members to contracted hospitals for conditions beyond the PCP's scope of practice that are medically necessary.

Hospital care is limited to Anthem benefits. Hospital professionals diagnose and treat conditions specific to their area of expertise. Hospital responsibilities include the following.

Supply Medications

Hospital providers must provide members with an adequate supply of medications upon discharge from the emergency room or an inpatient setting to allow reasonable time for the member to access a pharmacy to have prescriptions filled.

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 service is rendered.

In the event that the emergency room visit results in the member's admission to the hospital, providers must contact Anthem within 24 hours or one business day if the member was admitted on a weekend or holiday.

Notification of Prior Authorization Decisions

If the hospital has not received notice of prior authorization at the time of a scheduled admission or service as required by the Utilization Management guidelines and the Hospital Agreement, the hospital should contact Anthem and request the status of the decision.

Any admission or service that requires prior authorization and has not received the appropriate review may be subject to post-service review denial. Generally, the provider is required to perform all prior authorization functions with Anthem; however, the hospital may also ensure that prior authorization has been granted before services are rendered or risk post-service denial.

Ancillary Scope of Responsibilities

PCPs and specialists refer members to contracted network ancillary providers for conditions beyond the PCP's or specialist's scope of practice that are medically necessary.

Ancillary professionals diagnose and treat conditions specific to their area of expertise. Ancillary care is limited to Anthem benefits.

We have a wide network of participating healthcare professionals and facilities. All services provided by the healthcare professional and for which the healthcare professional is responsible are listed in the Ancillary Agreement.

Subcontractor Network Certification (SNC)

IN accordance with DHCS All Plan Letter 23-006, Delegation and Subcontractor Network Certification, Anthem is responsible for certifying that delegated groups are accountable for all network adequacy requirements as prescribed in APL 23-001 Network Certification Requirements.

As part of the Annual Network Certification (ANC), the Subcontractor Network Certification (SNC) is a process that entails monitoring of Subcontractors' and Downstream Subcontractors' provider networks. This is to submit documentation to DHCS to verify the compliance and/or noncompliance reported with the same standards applicable to Managed Care Plans for the ANC as prescribed in DHCS APL 23-001 Attachment A for network adequacy, DMHC APL25-019 and RY 2027 Provider Appointment Availability Survey Manual for timely access to care.

Delegated Groups (PMGS/IPAS): Access and Network Adequacy Standards

Anthem measures subcontractor access and network adequacy by:

1. Time or distance (see below for applicable provider and core specialist types)
2. Ease of getting an appointment timely (timely access): For Timely Access Standards see the section Access to Care, Appointment Standards, and After-hours Services, Appointment Standards.
3. Service fulfillment (Member Services, 24-hour triage)
4. Provider to enrollee ratios: Full time equivalent (FTE) ratios of one FTE PCP to every 2,000 members and one FTE physician to every 1,200 members.
5. Minimum number of network providers (Mandatory Provider Types): Mandatory Provider Type (MPT): A set of clinics and midwifery providers that Anthem must offer to contract with in each service area, where available based on MPT contracting requirements — MPTs include the following provider types:
    a. Federally Qualified Health Center (FQHC)
    b. Rural Health Clinic (RHC)
    c. Freestanding Birthing Center (FBC)
    d. Indian Health Facility (IHF)
    e. Certified Nurse Midwife (CNM)
    f. Licensed Midwife (LM)

Full time equivalent (FTE): Assumes the provider is available to serve plan members in the office setting eight hours a day, five days per week. DHCS measures FTE by setting the FTE of a provider to 20% at the plan parent level and then divides the provider into percentages based on the number of service areas, sites, and counties the provider serves.

Time or Distance

See the section Access to Care, Appointment Standards, and After-hours Services section, Network Adequacy Standards for more details.

Applicable provider types for DHCS time or distance standards:

- Adult Primary Care
- Pediatric Primary Care
- Adult Specialty Care
- Pediatric Specialty Care
- Adult Non-Specialty Mental Health (NSMH)
- Pediatric NSMH
- OB/GYN Specialty Care
- Hospitals
- Ancillary Services
- Member Services Line
- 24/7 Nurse Triage Line
- Dental Care
- Long-Term Services and Supports (LTSS) – Skilled Nursing Facility (SNF)
- LTSS – Immediate Care Facility (ICF)

DHCS adult and pediatric core specialists

- Cardiology/Interventional Cardiology
- Dermatology
- Endocrinology
- ENT/Otolaryngology
- Gastroenterology
- General Surgery
- Hematology
- HIV/AIDS Specialists/Infectious Diseases
- Nephrology
- Neurology
- Oncology
- Ophthalmology
- Orthopedic Surgery
- Physical Medicine and Rehabilitation
- Psychiatry
- Pulmonology

Circumstances for Network Certification Submission

Anthem is required to undergo a Subcontractor Network Certification annually, that is separate and distinct from the submission process for the Annual Network Certification (ANC).

SNC is also required:

- When a Subcontractor Network experiences a significant change:
- Significate change being an event that impacts the provision of healthcare services for 2,000 or more members, or
- When a Subcontractor Network change causes Anthem to become noncompliant with any of the network adequacy and access standards outlined in APL 23-001 or any superseding APLs.
- When Anthem enters into a new risk-based Subcontractor Agreement with a subcontractor that expands Anthem's existing provider network.

In either instance, Anthem must submit the applicable SNC documentation for only the Network adequacy and access standards impacted by the significant change or noncompliance.

If a significant change occurs within the 90 calendar days prior to the SNC annual submission date, Anthem can document the change as part of that RY SNC filing. For any significant changes that occur after the SNC annual submission date, Anthem should submit the applicable SNC documentation for only

the Network adequacy and access standards impacted by the significant change and report the change in the SNC for that RY.

Alternative Access Standards Issued by Anthem to Subcontracted Networks

Anthem will issue Alternative Access Standards (AAS) on an annual basis, or in the case of a SNC submission for a new Subcontracted Network implementation.

Anthem will be awarding Alternative Access Standards to Subcontracted Networks where Anthem's geo-mapping analysis shows network gaps based on methodology provided by DHCS. The Alternative Access Standards will be based on the time and distance of the nearest contracted provider – and under the condition that the Subcontracted Network has made good faith efforts to fill the gaps with expanded contracting efforts.

Anthem will conduct an analysis of the Subcontracted Network's service area to identify instances of noncompliance with DHCS Time or Distance standards by zip code, provider type, and population served. Anthem will notify the Subcontracted Network of the instance(s) of non-compliance, and our Alternative Access Standard process. If the Subcontracted Network cannot bring themselves into compliance with expanded contracting efforts, then they must request an Alternative Access Standard to avoid enforcement activity. Subcontracted Networks must submit AAS requests for the entire network annually. The annual AAS submission does not preclude the Subcontracted Network from submitting any significant changes since the previous reporting year.

Additional AAS requests may be submitted upon discovery of new network deficiencies.

Alternative Access Standard Process

Anthem conducts geo-mapping analysis based on methodology provided by DHCS to identify network gaps on an annual basis:

1. Anthem informs the Subcontracted Network of the gaps in their network, the nearest in-network provider, and the two closest out-of-network providers.
2. Subcontracted Network attempts to contract with two out-of-network providers for each deficiency noted.
3. Subcontracted Network submits completed Contracting Efforts template with unsuccessful contracting efforts and an Abbreviated Roster Template with successful contracting efforts.
4. Anthem will evaluate the submitted templates to determine if a good faith effort to contract was made by Subcontractor to complete the requirements of the Alternative Access Standards.

Anthem will conduct geo-mapping to monitor gaps in our Subcontracted Networks on a monthly and ad hoc basis.

Enforcement

If the subcontracted network is deficient in any of the standards listed above and has not been awarded an Alternative Access Standard request (in the case of Time or Distance Standards), Anthem will pursue enforcement actions, up to and including Corrective Action Plans (CAP) and contractual sanctions.

Access to Care, Appointment Standards, and After-Hours Services

Anthem adheres to standards set by the following regulators:

- National Committee for Quality Assurance (NCQA)
- American College of Obstetricians and Gynecologists (ACOG)
- Department of Health Care Services (DHCS)
- California Department of Managed Health Care (DMHC)
- LA Care Health Plan

These guidelines help ensure that medical appointments, emergency services and continuity of care for new members are provided fairly, reasonably and within specific time frames.

Anthem and state regulators monitor provider compliance with access to care standards on a regular basis. Timely Access surveys include, but are not limited to:

1. Anthem Provider Appointment Availability Survey (PAAS)
2. Anthem After-Hours Survey
3. DHCS Quarterly Timely Access Compliance Survey

Providers are required to participate in all Timely Access surveys from Anthem or any of its regulators listed above. Failure to comply with proper instructions, standards or survey requests may result in corrective action.

After-Hours Physician Exchanges (Answering Services)

Providers must instruct their after-hours answering service to answer Anthem's After-Hours survey questions.

Anthem monitors PCP compliance with after-hours access standards on a regular basis. It is recommended that PCPs advise their answering services to participate in any after-hours monitoring. Failure to comply may result in corrective action.

A common barrier to survey compliance is that the provider's After-Hours Physician Exchanges (answering service) are instructed not to participate in After-Hours surveys, leading to a non-compliant survey result. Non-compliant providers are subject to contractual enforcement actions, such as Corrective Action Plans (CAP) or escalated contractual sanctions for breach of contract.

We recommend the following suggested text for answering machines:

> "Hello, you have reached [insert physician office name] outside of our normal business hours of [insert office days and hours]. 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]."

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

After-Hours Services

It is Anthem policy and the state of California's requirement that our members have access to quality healthcare services 24 hours a day, 7 days a week. That kind of access means our PCPs must have a system in place to ensure that members can call after hours with medical questions or concerns.

PCPs must adhere to the following after-hours protocols:

- Forward member calls directly to a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to screen or triage an enrollee who may need care
- Ensure triage or screening waiting time does not exceed 30 minutes
- Ask the member if the call is an emergency. In the event of an emergency, they must immediately direct the member to **dial 911** or proceed directly to the nearest hospital emergency room.
- Have the ability to contact a telephone interpreter for members with language barriers.
- Return all calls.

Answering machine/service:

- May be used if staff or an answering service is not immediately available.
- Must instruct members with emergency healthcare needs to dial **911** or proceed directly to the nearest hospital emergency room.
- Must provide instructions on how to contact the PCP or on-call provider in a nonemergency situation.
- Must inform the members of their routine office hours for members with non-urgent or non-emergent matters.
- Must provide instructions in English, Spanish and any other language appropriate to the PCP's practice.

Americans with Disabilities Act Requirements

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

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

Human Trafficking

To comply with AB1740, California Civil code 52.6, and the increase in human trafficking over the course of the last couple years, emergency rooms within general acute care hospitals, urgent cares, and facilities that provide pediatric care (services provided to members from birth to 21 years of age, including labor and delivery) must post a prescribed notice containing information about slavery and human trafficking.

This required notice, developed by the California Department of Justice is available in 23 languages, includes details on how to seek help, report unlawful activity, and support and services available to human trafficking victims. The notice "STOP Human Trafficking" in English, Spanish, and additional languages can be found on the California Department of Justice (oag.ca.gov) > **Programs** > **Human Trafficking** > **Human Trafficking Model Notice** or directly at oag.ca.gov/human-trafficking/model-notice.

The notice must be at least 8.5x11-inch paper in 16-point font and must be posted near a public entrance or clear view of the public.

Victims of slavery and human trafficking are protected under United States and California Law.

- Text: **233-733**
- Call: **888-373-7888** (National Human Trafficking Hotline)
- Call: **888-539-2373** (California Coalition to Abolish Slavery and Trafficking (CAST)

Alternate Format Selection

Member informing materials such as documents that are vital or critical to obtaining benefits or services, including but not limited to: communications, marketing information, form letters including Notice of Actions (NOA), notices related to grievances or appeals, preventive health reminders, member surveys, notices advising of the availability of free language assistance, and newsletters must be translated into the member's alternative format selection.

The standard alternative format options are large print, audio CD, data CD, and Braille. Below are descriptions of each format:

- Large print: No less than 20-point size Arial font.
- Audio CD: Provides the ability to hear notices and information. Files in the CD are not encrypted. (for example., not password protected unless requested)
- Data CD: This allows for the use of computer software to read notices and other written information. Files in the CD are not encrypted (for example., not password protected unless requested)
- Braille: Uses raised dots that can be read with fingers.
- Requests for other auxiliary aids and services that may be appropriate.

There are also non-standard alternative formats:

- Encrypted audio CD: Provides the ability to hear notices and information. Files for Medi-Cal notice in the CD are protected with a password.
- Encrypted data CD: This allows for the use of computer software to read notices and other written information. Files for Medi-Cal notice in the CD are protected with a password.

Pain Management Contract

A written agreement between a provider and member that the member will not misrepresent their need for medication. If the contract is violated, the provider has the right to drop the member from their practice.

Appointment Standards

Healthcare providers must make appointments for members from the time of request as follows:

Emergency examination	Immediate access, 24 hours/7 days a week
Urgent (sick) examination	Within 48 hours of request if authorization is not required or within 96 hours of request if authorization is required, or as clinically indicated (Urgent standards include weekends and holidays).
Routine primary care examination (nonurgent)	Within 10 business days of request
Nonurgent consults/specialty referrals	Within 15 business days of request
Nonurgent care with nonphysician mental health providers or substance use disorder (where applicable)	Within 10 business days of request
Nonurgent follow-up care with nonphysician mental health providers or substance use disorder provider (where applicable)	Within 10 business days of request
Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition	Within 15 business days of request
Initial health appointments	Within 120 days of enrollment
Preventive care visits	Within 14 days of request
Routine physicals	Within 30 days of request
Behavioral health	
Standards for timely and appropriate access to quality behavioral healthcare	Emergent: immediately Emergent, nonlife threatening/crisis stabilization: within 24 hours of request Urgent: within 48 hours of referral/request Initial visit for routine care within 10 business days
Outpatient treatment by a behavioral health provider post inpatient discharge	7 calendar days Routine outpatient: within 10 days of request Outpatient following discharge from an inpatient hospital: within 7 days of discharge
Initial health appointments	
Children under the age of 18 months	Within 120 days of enrollment or within American Academy of Pediatrics (AAP) guidelines, whichever is less
Children aged 19 months and over	Within 120 days of enrollment
Prenatal and post-partum visits	
First prenatal visit	Within 10 days of request
First and second trimester	Within 7 days of request
Third trimester	Within 3 days of request
High-risk pregnancy	Within 3 days of identification
Postpartum	Between 7 and 84 days after delivery

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 any refusals by the member.

Documentation of the attempts to schedule an **initial health appointment** must be available to Anthem or state reviewers upon request.

PCP-initiated Member Changes

Primary care physicians (PCPs), Physician groups, and independent practice associations (IPAs) acting on behalf of a PCP may request for Anthem to transfer a member to another PCP. Provider initiated PCP changes can only be obtained due to moral objection and or breakdown of the provider member relationship.

Patients cannot be discriminated against in the delivery of healthcare services, consistent with the benefits covered in their policy, based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, source of payment, health status or participation in Medi-Cal. Accordingly, a transfer request may not be based on any of these factors, or on the amount or cost of the service that a patient requires.

Anthem will evaluate and process the PCP change, effective within 30 days. Members will be assigned a new PCP and be issued a new Anthem ID card.

PCPs can request that a member be assigned to another PCP by completing the Provider Request for Member Deletion from PCP Assignment form or go to providers.anthem.com/CA > **Forms** > **For Providers**.

Specialists

The following guidelines are in place for our specialists:

- For urgent care, the specialist should see the member within 24 hours of receiving the request.
- For routine care, the specialist should see the member within 15 business days of receiving the request.
- A copy of the medical records and/or results of the visit should be sent to PCP office also to allow continuity of care.

In some cases, a member may self-refer to a specialist. These cases include but are not limited to:

- Family planning and evaluation
- Diagnosis, treatment, and follow-up of sexually transmitted diseases (STDs)

Note: Specialists are responsible for ensuring that necessary pre-authorizations have been obtained prior to providing services.

For some medical conditions, it makes sense for the specialist to be the PCP. Members may request that the specialist be assigned as their PCP if:

- Member has a chronic illness
- Member has a disabling condition
- Member is a child with special healthcare needs

Office Hours

To maintain continuity of care, providers are required to be available to provide services for a minimum of 20 hours each week (16 hours in LA County), eight hours of which, a physician shall be on site to provide services. Office hours must be clearly posted, and members must be informed about the provider's availability at each site. There are strict guidelines for providing access to healthcare **24 hours a day**, **7 days a week**:

- Providers must be available 24 hours a day by telephone.
- During those times when a provider is not available, an on-call provider must be available to take calls.

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 either take the call or call the member back within 30 minutes of the initial call.
- When an Anthem member arrives on time to an appointment, the member should be seen within 15 minutes of the scheduled appointment.
- When Anthem members and/or prospective members call a physician's office, they should not be placed on hold for longer than 10 minutes.

Non-discrimination Statement

Providers must post a statement in their offices that details hours of operation that do not discriminate against Anthem members. This includes wait times for the following:

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

Interactive Voice Response Requirements of Providers

The following providers are required to have 24-hour service:

- Assisted living facilities/services
- Emergency response systems
- Nursing homes/skilled nursing facilities

Such providers will provide advice and assess care as appropriate for each member's medical condition. Emergent conditions will be referred to the nearest emergency room.

Network Adequacy Standards

Below are the Department of Health Care Services (DHCS) Network Adequacy Standards as outlined in All Plan Letter 23-001.

Provider type	Timely Access Standard	Rural county - Time or Distance Standard	Small county -Time or Distance Standard	Medium county - Time or Distance Standard	Dense county - Time or Distance Standard
Primary Care (Adult and Pediatric)	Within 10 business days of request for appointment	10 miles or 30 minutes from any member or anticipated member's residence			
Specialty Care (Adult and Pediatric)	Within 15 business days of request for appt.	60 miles or 90 minutes from any member or anticipated member's residence	45 miles or 75 minutes from any member or anticipated member's residence	30 miles or 60 minutes from any member or anticipated member's residence	15 miles or 30 minutes from any member or anticipated member's residence
Obstetrics/Gynecology (OB/GYN) Primary Care	Within 10 business days of the request for appt.	10 miles or 30 minutes from any member or anticipated member's residence			
OB/GYN Specialty Care	Within 15 business days of request for appt.	60 miles or 90 minutes from any member or anticipated member's residence	45 miles or 75 minutes from any member or anticipated member's residence	30 miles or 60 minutes from any member or anticipated member's residence	15 miles or 30 minutes from any member or anticipated member's residence
Hospitals	Not Applicable	15 miles or 30 minutes from any member or anticipated member's residence			
Dental Providers	Non-urgent: Within 36 business days of request for appt. Preventive: Within 40 business days of request for appt.	10 miles or 30 minutes from any member or anticipated member's residence			
Non-Specialty Mental Health Providers (Adult and Pediatric)	Within 10 business days of request for appt.	60 miles or 90 minutes from any member or anticipated member's residence	45 miles or 75 minutes from any member or anticipated member's residence	30 miles or 60 minutes from any member or anticipated member's residence	15 miles or 30 minutes from any member or anticipated member's residence

Provider type	Timely Access Standard	Rural county - Time or Distance Standard	Small county -Time or Distance Standard	Medium county - Time or Distance Standard	Dense county - Time or Distance Standard
Ancillary Services	Within 15 business days of request for appt.				
Long Term Services and Supports (LTSS)	If applicable	Time or distance standards are not established for Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP), Skilled Nursing Facilities (SNF), or Intermediate Care Facilities (ICF) providers, as these providers either travel to the member to provide services or the member resides at the facility for care.			

Table 1: County Size Categories by Population			
Size Category	Population Density	# of Counties	Counties
Rural	≤50 people per square mile	21	Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Tuolumne, Trinity
Small	51 to 200 people per square mile	19	Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa, Barbara, Sutter, Tulare, Yolo, Yuba
Medium	201 to 599 people per square mile	9	Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, Ventura
Dense	≥600 people per square mile	9	Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, Santa Clara

Table 2: DHCS Adult and Pediatric Core Specialists	
Cardiology/Interventional Cardiology	Nephrology
Dermatology	Neurology
Endocrinology	Oncology
ENT/Otolaryngology	Ophthalmology
Gastroenterology	Orthopedic Surgery
General Surgery	Physical Medicine and Rehabilitation
Hematology	Psychiatry
HIV/AIDS Specialists/Infectious Diseases	Pulmonology

Table 3: LTSS Timely Access Network Standards				
Provider Type	Rural Timely Access Standard	Small Timely Access Standard	Medium Timely Access Standard	Dense Timely Access Standard
SNF	Within 14 calendar days of request	Within 14 calendar days of request	Within 7 business days of request	Within 5 business days of request
Intermediate Care Facility/Developmentally Disabled (ICF-DD)	Within 14 calendar days of request	Within 14 calendar days of request	Within 7 business days of request	Within 5 business days of request
Community Based Adult Services (CBAS)	Capacity cannot decrease in aggregate statewide below April 2012 level			

Table 4: Call Center Wait Time Standards	
Medi-Cal Managed Care Health Plan (MCP) Call Center	10 minutes from the time call is placed.

Table 5: DHCS Telehealth Providers	
Cardiology/Interventional Cardiology	Neurology
Dermatology	Non-Specialty Mental Health providers
Endocrinology	OB/GYN
ENT/Otolaryngology	Oncology
Gastroenterology	Ophthalmology
Hematology	Primary Care
HIV/AIDS Specialists/Infectious Diseases	Psychiatry
Nephrology	Pulmonology

Required Assessments

The initial health appointment (IHA) is a complete medical history, head-to-toe physical examination, and assessment of health behaviors.

The IHA provides you with the opportunity to perform, or refer a member to, many preventive healthcare services required by HEDIS (Healthcare Effectiveness Data and Information Set)®, such as childhood well visits, immunizations, and well-woman care.

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

IHA must be performed by a Provider within the primary care medical setting, provided in a way that is culturally and linguistically appropriate for the member, and must be documented in the member's medical record.

The IHA should include but is not limited to the following specific screenings:

- A comprehensive past medical and psycho-social history
- Preventive services
- Health education
- An identification of risks
- Comprehensive physical exam
- Diagnoses and plan of care
- Developmental and behavioral assessment
- Vaccines as recommended by the ACIP
- Documented parental anticipatory guidance and Blood Lead Level testing for children
- Dyadic Services and Family Therapy Benefit

PCPs are strongly encouraged to review their monthly eligibility list available on the Anthem provider website and to proactively contact their assigned members to make an appointment for an IHA within the following time frame:

- All new members must have an IHA within 120 days of enrollment.

The PCP's office is responsible for making and documenting all attempts to contact assigned members. Members' medical records must reflect the reason for any delays in performing the IHA including any refusals by the member to have the exam.

An initial health appointment is **not** necessary under the following conditions:

- If the new member is an existing patient of the PCP (but new to the Anthem network) with an established medical record showing baseline health status. This record must include a documented IHA within the past 12 months prior to the member's enrollment and sufficient information for the PCP to provide treatment.
- If the new member is not an existing patient, transferred medical records can also meet the requirements for an IHA if a completed health history is included.
- If the new member refuses to schedule an IHA. The refusal must be documented in the member's medical record.

Health Information form/Member Evaluation Tool (HIF/MET) and Health Risk Assessment (HRA)

We strongly encourage providers assist members in completing the Health Information form/Member Evaluation Tool (HIF/MET). This 10-minute state-required health screener is included in all new members' welcome packets and should be returned to Anthem within 90 days of enrollment. This information is private. Information collected in the health screener ensures members get the most out of their health plan.

For Senior and Persons with Disabilities who are identified as high-risk, an additional assessment is completed to identify and support coordination of physical health, mental health, and social determinant of health needs. For example, if member needs assistance with coordinating specialty services, we will help schedule an exam with a specialty provider. Or, if your member has to refill a prescription, we can assist the member with navigating their pharmacy benefits. These are just a few of many services Anthem can assist you with. We help our members stay connected to care and prevent unnecessary emergency room visits or hospitalizations.

Dyadic Services and Family Therapy Benefit

We strongly encourage providers to, within the child-caregiver dyad, assess and refer for developmental and behavioral health conditions of children as soon as they are identified, and foster coordination of care, child social-emotional health and safety, developmentally appropriate parenting, and caregiver and child behavioral health.

Dyadic Services include Dyadic behavioral health (DBH) well-child visits, Dyadic Comprehensive Community Supports Services, Dyadic Psychoeducational Services, and Dyadic Family Training and Counseling for Child Development. Dyadic services are available to members under age 21 and their parent(s)/caregiver(s). The parent(s) or caregiver(s) does not need to be enrolled in Medi-Cal or have other coverage so long as the care is for the direct benefit of the child. No prior authorization is required to deliver dyadic services.

Pregnancy Notification

- providers.anthem.com/CA > **Forms** > **Pregnancy and Maternal Child Services** > **Pregnancy Notification form**
- Fax: **855-410-4451**

The pregnancy notification process identifies Anthem members who are covered by Medi-Cal Managed Care (Medi-Cal) early in their pregnancy. Our goal is to identify women who may need additional health education, transportation assistance, case management (including high-risk obstetrics), care coordination and any other needs related to women's health. The Maternity Notification form provides important information to Anthem so that we can ensure pregnant members access prenatal care timely within their first trimester or within 42 days of enrollment as recommended by National Committee for Quality Assurance (NCQA).

We require notification of pregnancy at the first prenatal visit. The Maternity Notification form can be found on the Anthem provider website located under *Pregnancy and Maternal Child Services* following the link at the beginning of this section. You may fax the forms to Anthem at **855-410-4451**.

Preventive Healthcare

Current educational materials and health management programs are located on our provider website > **Resources** > **Training Academy** or directly at providers.anthem.com/california-provider/resources/provider-training-academy.

With respect to the issue of coverage, each member should review their Evidence of Coverage for details concerning benefits, procedures, and exclusions prior to receiving treatment.

The Evidence of Coverage supersedes the preventive health guideline recommendations.

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 of California. With respect to the issue of coverage, each member should review their Evidence of Coverage for details concerning benefits, procedures, and exclusions prior

to receiving treatment. The Evidence of Coverage supersedes the preventive health guideline recommendations.

Preventive Health Coverage

In compliance with DMHC APL 25-015 and AB144, Anthem covers preventive services and immunizations as required by California law and DMHC guidance, including APL 25-015 (AB 144). Covered preventive services include those recommended by federal preventive-care bodies (for example, USPSTF) as of January 1, 2025, and as supplemented or modified by the California Department of Public Health (CDPH). These covered preventive services are provided consistent with applicable requirements regarding member cost-sharing and utilization management. When CDPH publishes updates to preventive care recommendations, we will implement required coverage updates within the required time frame and will communicate relevant changes to the network through provider bulletins and updated billing/coverage guidance.

Preventive Healthcare Guidelines

The most up-to-date Preventive Healthcare Guidelines are located on our website at providers.anthem.com/CA.

Anthem considers Preventive Health Guidelines to be an important component of healthcare. Anthem develops preventive health guidelines in accordance with recommendations made by nationally recognized organizations and societies such as the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the Advisory Committee on Immunizations Practices (ACIP), the American College of Obstetrics and Gynecology (ACOG) and the United States Preventive Services Task Force (USPSTF).

The above organizations make recommendations based on reasonable medical evidence. We review the guidelines annually for content accuracy, current primary sources, new technological advances, and recent medical research and make appropriate changes based on this review of the recommendations and/or preventive health mandates. We encourage physicians to use these guidelines to improve the health of our members.

Clinical Practice Guidelines

Several national organizations produce guidelines for asthma, diabetes, hypertension, and other conditions. The guidelines, which Anthem uses for quality and disease management programs, are based on reasonable medical evidence. We review the guidelines at least every two years or when changes are made to national guidelines for content accuracy, current primary sources, new technological advances, and recent medical research.

Clinical Practice Guidelines can be downloaded at providers.anthem.com/california-provider/resources/manuals-policies-guidelines. You can also call Provider Services at **866-231-0847** to receive a copy.

Comprehensive Perinatal Services Program

The Comprehensive Perinatal Services Program (CPSP) is a Medi-Cal program that provides individualized perinatal services during pregnancy and 60 days following delivery by or under the personal supervision of a physician approved by CPSP. All members must be offered CPSP services.

The program emphasizes nutritional services, psychosocial support, health education and postpartum treatment and intervention.

PCPs caring for pregnant women and obstetrics/gynecology specialists are responsible for assessing member needs and referring all pregnant members to the following:

- Community prenatal services
- Women, Infants and Children Program (WIC)
- Substance use programs
- Prenatal education classes

Women should be referred to a CPSP provider by calling the appropriate Customer Care Center at the numbers listed at the beginning of this chapter.

Immunization Program

The Immunization Program was designed to increase both childhood immunization rates and the number of members who are fully immunized.

Advisory Committee on Immunization Practices (ACIP) has recommended immunizations for all children as well as adult members.

Providers must ensure timely provision of immunization to members in accordance with the most recent schedule and recommendation published by ACIP, regardless of a member's age, sex, or medical condition, including pregnancy. All members should be notified by the PCP of the use of the California Immunization Registry (CAIR) to monitor immunizations administered to all members.

Providers must document each member's need for ACIP recommended immunizations as part of all regular health visits. ACIP recommended immunizations are viewed as preventive services and will not require a Prior Authorization.

Medi-Cal pharmacy providers who are enrolled as VFC providers may administer VFC funded vaccines to VFC-eligible Medi-Cal members. The vaccines must be administered in accordance with ACIP recommendations and report the administration of any vaccine within 14 days.

Providers should be working with the CAIR program, so all immunization information is obtained by CAIR whether by inputting data, upload, or transfer of information.

When immunizations are given, the PCP must also distribute the Vaccine Information Statement (VIS) that educates on the vaccines administered prior to having their vaccines administered.

All pediatric providers must participate in the Vaccines for Children (VFC) program. The VFC program supplies free vaccines to children less than 19 years old who qualify for Medi-Cal, are uninsured, or are American Indian, or Alaska Native.

For more information about up-to-date routine and non-routine Vaccines, recommended Immunization schedules for persons Age 0 to 18 years old and Adults please visit the CDC website or go to cdc.gov/vaccines/hcp/imz-schedules/child-adolescent-age.

Well Woman

The Well Woman Program was developed to remind and encourage women to have regular cervical and breast cancer screenings. The Well Woman Reminder Program sends a screening test reminder mailer to women who are not up to date with their recommended cervical and/or breast cancer screenings.

Providers are encouraged to refer members for screenings and/or schedule the exams. PCP responsibilities for the care of female members include:

- Educating members on Preventive Healthcare Guidelines for women
- Referring members for cervical and breast cancer screenings
- Scheduling screening exams for members

Breastfeeding

The American Academy of Pediatrics, the American College of Obstetrics and Gynecology, and the American Public Health Association recognize breastfeeding as the preferred method of infant feeding. Providers should encourage breastfeeding for all pregnant women unless it is not medically appropriate.

To support this goal, providers should do the following:

- Refer pregnant women to community resources that support breastfeeding such as La Leche League, WIC and breastfeeding classes.
- Assess all pregnant women for health risks that are contraindications to breastfeeding (for example, AIDS and active tuberculosis).
- Provide breastfeeding counseling and support to postpartum women immediately after delivery.
- Assess postpartum women to determine the need for lactation durable medical equipment (DME) such as breast pumps and breast pump kits.
- Document all referrals and treatments related to breastfeeding in the patient's medical record (pediatricians should document frequency and duration of breastfeeding in baby's medical record).
- Refer members to breastfeeding classes prior to delivery by calling our Customer Care Center.
- Support continued breastfeeding at the postpartum visit.

Lactation management aids are a covered benefit for Medi-Cal members. Members can obtain hand-held breast pumps through a prescription without prior authorization. In addition, the following services are available:

- Electric breast pumps are available for members with medical necessity with a provider referral and prior authorization. Contact Utilization Management for more information:

Arrangement for the provision of human milk for newborns must be made if the mother is unable to breastfeed due to medical reasons and/or the infant cannot tolerate or has medical contraindications to the use of any formula including elemental formulas. The **Mother's Milk Bank** and **UC Health Milk Bank** are the only two human milk banks in the state of California:

Mothers Milk Bank (San Jose):	UC Health Milk Bank (San Diego):
1887 Monterey Rd. Suite 110 San Jose, CA 95112 **408-998-4550**	3636 Gateway Center Ave. Suite 102 San Diego, CA 92102 **858–249-6455**

Restrictions on AI Use in Performing a Health Plan Function

Providers who have been delegated to perform a health plan function (for example, Utilization Management, credentialing and/or claims payment) shall not use AI in the performance of any delegated health plan function without the advance written consent of the health plan. Providers shall request such approval in accordance with the notice provisions of the provider agreement and the health plan shall provide its' written response in accordance with the notice provisions of the provider agreement.

Chapter 9: Administrative Procedures

Enforcement and Escalation for Non-compliance with Standards

Anthem maintains a monitoring and oversight program to ensure compliance with contract and regulatory requirements.

When deficiencies are identified through monitoring activities, Anthem may initiate corrective action to remedy the deficiency.

In general, if a Corrective Action Plan (CAP) is not resolved within the cure period or within three months of initial notification of deficiency, a CAP would be escalated via recommendation and approval by the appropriate committee for additional contract enforcement. Escalation includes, but is not limited to:

- Outreach to PMG/Provider via meeting
- Formal Notice of Findings
- Corrective Action Plan
- Warning Letter
- Breach Notice
- Recoverable Cap Withhold
- Non-Recoverable Cap Withhold
- Sanction/CAP Deduction (non-recoverable)
- Sending a quality performance notices that requires completion of specific QI interventions
- Membership/Panel Freeze
- De-delegation
- Termination

Provider Termination, Location, Covered Services and Population Served Changes

If a provider who is part of a participating medical group (PMG) and/or an independent practice association (IPA) decides to terminate from the Anthem network, changes location or changes their population served the following guidelines must be followed:

The PMGs/IPAs should notify Anthem. The provider's termination and/or changes will become effective no less than 120 calendar days after we receive notification.	The provider's decision to terminate from Anthem could impact participation in other Anthem lines of business and may prevent the provider from participating with us in the future.

If a provider who is part of the Anthem network terminates their contract, changes location, and or changes the population they serve, the following guidelines must be followed:

The provider should notify Anthem within a minimum of 120 calendar days written notice to ensure timely member notifications can be sent.	The provider's termination and/or changes will become effective no less than 120 calendar days after we receive notification.

The provider's decision to terminate from Anthem could impact participation in other Anthem lines of business and may prevent the provider from participating with Anthem in the future.

It is imperative that these minimum timelines be met to ensure members, the California Department of Managed Health Care, the California Department of Health Care Services and the health plan are notified as required, ensuring systems are updated in a timely manner. Future instances of untimely

notification will result in issuance of a corrective action plan, including, but not limited to, financial sanctions and/or a breach of contract notice.

Contract Termination with Health Plan

When a participating provider notifies Anthem that the provider is terminating the contract with the network, we notify all members that the provider will no longer be available. A terminating provider who is actively treating members must continue to treat members until the provider's date of termination.

Impacted members are notified about the termination and provided the following information:

- The impending termination date of their provider
- Their right to request continued access to care
- Contact information to request a PCP change
- The DHCS Ombudsman phone number
- Referrals to Utilization Management for continued access to care consideration
- The opportunity to choose a new PCP or be assigned to a new PCP with the option to change if the member does not choose a PCP
- All other notification language required by the H&S Code and the DHCS All Plan Letter, Medi-Cal provider and subcontract suspensions, terminations, and decertification

Members under the care of specialists can also submit requests for continued access to care including continued care after the transition period by calling the appropriate Medi-Cal Customer Care Center:

Location	Customer Care Center Phone
L.A. County	**888-285-7801** Monday to Friday, 7 a.m. to 7 p.m.
Outside L.A. County	**800-407-4627** Monday to Friday, 7 a.m. to 7 p.m.
TTY	**888-757-6034** (**TTY 711**)

Termination or Affiliation Change with Provider Groups

Anthem PCPs may have multiple provider medical group (PMG) affiliations. To ensure continuity of care, membership will remain with an assigned PCP unless the PCP does not have another Anthem PMG affiliation.

A PCP can change PMG affiliations. Assigned members will transfer to follow the PCP under the new affiliation. The following exceptions to this policy shall occur:

- If the PCP is an employee of the PMG (except in L.A. County), member affiliation will remain with the PMG. Members may elect to change this PMG affiliation to the PCP's new affiliation in order to facilitate continued care under the established PCP:

If the PCP in L.A. County has an active PMG affiliation with LA. Care or its Plan Partners outside of Anthem, members will be transitioned to the active health plan.

- If a member is assigned to a safety net clinic, the member's affiliation remains with the clinic should a PCP terminate its affiliation.
- If a provider is a supervising physician, then the provider must update Anthem with the new supervising physician.

Continuity of Care Provision for a PMG-Employed Physician

If the PMG does not have the appropriate PCP specialty to serve members that were assigned to a departing employed physician, Anthem has the right to move the affected member to the PCP's new PMG affiliation or an appropriate PMG.

For example, If the only pediatrician affiliated with the PMG terminates his employment or his employment is terminated, Anthem will move members to an alternate PMG affiliation to ensure the affected members have access to appropriate pediatric care. If the PCP changes PMG affiliation and relocates his practice further than 10 miles, Anthem also has the right to select a new PCP for the affected membership.

Network education representatives (NERs) are the primary account managers for all provider services associated with an assigned PMG. The NERs also serve as liaisons between Anthem and the provider network for many providers who exist outside of the PMG including hospital, ancillary and individual providers.

The NER is responsible for coordinating all additions, changes and terminations from the PCP and PMG.

Provider Terminations from Groups

When a provider who is part of a PMG and/or an independent practice association (IPA) decides to terminate from the Anthem network, the following guidelines must be followed:

- The PMGs/IPAs should notify Anthem. The provider's termination will become effective 120 days after we receive notification.
- Special consideration may be given in situations which render compliance with the 120-day requirement impossible (for example, death of a provider, natural disaster)
- The provider's decision to terminate from Anthem could impact participation in other Anthem lines of business and may prevent the provider from participating with us in the future.

Note: If we determine that the quality of care or services provided by a healthcare professional is not satisfactory as evidenced by member satisfaction surveys, member complaints or grievances, utilization management data, complaints or lawsuits alleging professional negligence, or any other quality of care indicators, Anthem may terminate the Provider Agreement.

Updating Provider Directories

Anthem providers are required to inform us of any material changes to their practice, either through voluntarily effort or through mandatory response to Anthem provider outreach efforts in compliance with Senate Bill 137 (SB137) including:

- Change in professional business ownership
- Change in business address or the location where services are provided
- Change in federal 9-digit Tax Identification Number (TIN)
- Change in specialty
- The age range of patients serviced by the provider
- Languages spoken by both provider and midlevel staff
- Change in demographic data (for example: phone numbers, fax numbers, email address, handicap or ADA accessibility and office hours)
- Hospital admitting privileges
- Legal or governmental action initiated against a healthcare professional including, but 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 care review and grievance resolution procedures
- Notification that the provider is accepting new patients

Failure to respond within the designated time frame indicated on the outreach form **will result in suppression from the provider directory**.

Submissions provided voluntarily unrelated to the SB137 outreach do not satisfy this requirement. There must be a response to the SB137 outreach form.

Quarterly Roster Validation

Anthem has established a quarterly Roster Automation to streamline and automate provider data additions, changes, and terminations using a standardized Microsoft Excel submission. This is in compliance with SB137. Anthem providers are required to respond within the deadlines provided with accurate and complete updates of provider rosters, using the Roster Automation Standard Template. For instructions, refer to the first tab of the template, titled User Reference Guide.

Providers must upload their completed roster via the Availity PDM application.

Failure to comply with any SB137 related outreach, including use of Anthem's templates, could lead to a request for corrective action plan. Repeated noncompliance could lead to contractual action.

Updating Provider Information

For voluntary updates separate from the SB137 outreach, use the new online Provider Maintenance form (PMF) to notify Anthem of changes. The form is available in the *Forms* library on the *Provider Resources* page of our website at providers.anthem.com/CA.

For directions on how to access Availity Essentials, see Chapter 2: Quick Reference of this manual.

Updating Delegate Contact List

Anthem must receive any changes in the status of the executive-level personnel for Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors including, but not limited to the chief executive officer, chief financial officer, chief operations officer, the medical director, the chief health equity officer, and the compliance officer and government relations persons within 20 calendar days

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Chapter 10: Credentialing & Recredentialing

Anthem's Discretion

The credentialing summary, criteria, standards, and requirements set forth herein are not intended to limit Anthem's discretion in any way to amend, change or suspend any aspect of Anthem's credentialing program ("Credentialing Program") nor is it intended to create rights on the part of practitioners or HDOs who seek to provide healthcare services to Members. Anthem further retains the right to approve, suspend, or terminate individual physicians and healthcare professionals, and sites in those instances where it has delegated credentialing decision making.

Credentialing Scope

Credentialing requirements apply to the following:

1. Practitioners who are licensed, certified or registered by the state to practice independently (without direction or supervision);
2. Practitioners who have an independent relationship with Anthem
    a. An independent relationship exists when Anthem directs its Members to see a specific practitioner or group of practitioners, including all practitioners whom a member can select as primary care practitioners; and
3. Practitioners who provide care to Members under Anthem's medical benefits.

The criteria listed above apply to practitioners in the following settings:

- Individual or group practices
- Locum tenens:
- Provisional Credentialing is required if these practitioners work less than 60 calendar days.
- Full Credentialing is required if these practitioners work 60 calendar days or more.
- Covering practitioners (for example, locum tenens) who do not have an independent relationship with the Company are not included in the Credentialing scope.
- Facilities
- Rental networks
    - That are part of Anthem's primary Network and include Anthem Members who reside in the rental network area.
    - That are specifically for out-of-area care and Members may see only those practitioners or are given an incentive to see rental network practitioners; and
- Telemedicine
- PPO network:
    - If an organization contracts with a PPO network to provide health services to members who need care outside its service area, and if it encourages members to obtain care from that network when they are outside the network, NCQA considers this to be an
    - independent relationship if:
        - Information about the network is included in member materials or on an ID card that directs members to the network (for example, network name, phone number, logo), or
    - There are incentives for members to see the PPO's practitioners.
        - In this type of contractual arrangement, the organization must credential the
        - practitioners or delegate credentialing to the PPO network.

Anthem credentials the following licensed/state certified independent healthcare practitioners:

- Medical Doctors (MD)
- Doctors of Osteopathic Medicine (DO)
- Doctors of Podiatry
- Chiropractors
- Optometrists providing Health Services covered under the Health Benefit Plan
- Doctors of dentistry providing Health Services covered under the Health Benefit Plan including oral and maxillofacial surgeons
- Psychologists who have doctoral or master's level training
- Clinical social workers who have master's level training
- Psychiatric or behavioral health nurse practitioners who have master's level training
- Other behavioral healthcare specialists who provide treatment services under the Health Benefit Plan
- Telemedicine practitioners who provide treatment services under the Health Benefit Plan
- Medical therapists (for example, physical therapists, speech therapists, and occupational therapists)
- Genetic counselors
- Audiologists
- Acupuncturists (non-MD/DO)
- Nurse practitioners
- Certified nurse midwives
- Physician assistants (as required locally)
- Registered Dietitians

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

- Certified behavioral analysts
- Certified addiction counselors
- Substance use disorder practitioners

Anthem credentials the following Health Delivery Organizations (HDOs):

- Hospitals
- Home health agencies
- Skilled nursing facilities (Nursing Homes)
- Ambulatory Surgical Centers
- Behavioral health facilities providing mental health and/or substance use disorder treatment in inpatient, residential or ambulatory settings, including:
  - Adult family care/foster care homes
  - Ambulatory detox
  - Community Mental Health Centers (CMHC)
  - Crisis Stabilization Units
  - Intensive Family Intervention Services
  - Intensive Outpatient – Mental Health and/or Substance Use Disorder
  - Methadone Maintenance Clinics
  - Outpatient Mental Health Clinics
  - Outpatient Substance Use Disorder Clinics

    - Partial Hospitalization – Mental Health and/or Substance Use Disorder
    - Residential Treatment Centers (RTC) – Psychiatric and/or Substance Use Disorder
- Birthing Centers
- Home Infusion Therapy when not associated with another currently credentialed HDO
- Durable Medical Equipment providers

The following HDOs are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process as directed by CMS including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)
- End Stage Renal Disease (ESRD) service providers (dialysis facilities) (CMS Certification or National Dialysis Accreditation Commission
- Portable x-ray Suppliers (CMS Certification)
- Home Infusion Therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)
- Federally Qualified Health Centers (FQHC) (CMS Certification)
- Rural Health Clinics (CMS Certification)
- Orthotics and Prosthetics Suppliers (American Board for Certification in Orthotics and Prosthetics_(ABCOP) or Board of Certification/Accreditation (BOC) or The National Examining Board of Ocularists (NEBO))

Credentials Committee

The decision to accept, retain, deny or terminate a practitioner's or HDO's participation in on one or more of Anthem's networks or plan programs is conducted by a peer review body, known as Anthem's Credentials Committee (the "CC").

The CC will meet at least once every 45 calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the Vice President of Medical and Credentialing Policy, will designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. In states or regions where Medicare Advantage (MA) is represented, a second vice-chair representing MA may be designated. In states or regions where an Anthem affiliated provider organization is represented, a second vice-chair representing that organization may be designated. The chair must be a state or regional lead medical director, or an Anthem medical director designee and the vice-chair must be a lead medical officer or an Anthem medical director designee, for that line of business not represented by the chair. In states or regions where only one line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five, but no more than 10 external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types of credentialed health providers (for example, nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair's discretion. At least two of the physician committee members must be credentialed for each line of business (for example, Commercial, Medicare,

and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels their judgment might otherwise be compromised. A committee member will also disclose if they have been professionally involved with the practitioner. Determinations to deny an applicant's participation or terminate a practitioner from participation in one or more Networks or Plan programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are network practitioners.

During the credentialing process, all information that is obtained is confidential and not subject to review by third parties except to the extent permitted by law. Access to information will be restricted to those individuals who are deemed necessary to attain the objectives of the Credentialing Program. Specifically, information supplied by the practitioner or HDO in the application, as well as other non-publicly available information will be treated as confidential. Confidential written records regarding deficiencies found, the actions taken, and the recommended follow-up will be kept in a secure fashion. Security mechanisms include secured office facilities and locked filing cabinets, a protected computer infrastructure with password controls and systematic monitoring, and staff ethics and compliance training programs. The procedures and minutes of the CC will be open to review by state and federal regulatory agencies and accrediting bodies to the extent permitted by law.

Practitioners and HDOs are notified of their right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, Anthem's credentialing staff ("Credentialing Department") will contact the practitioner or HDO within 30 calendar days of the identification of the issue. This communication will notify the practitioner or HDO of their right to correct erroneous information or provide additional details regarding the issue and will include the process for submission of this additional information. Depending on the nature of the issue, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue, including copies of the correspondence or a detailed record of phone calls, will be documented in the practitioner's or HDO's credentials file. The practitioner or HDO will be given no less than 14 calendar days in which to provide additional information. Upon request, the practitioner or HDO will be provided with the status of their credentialing or re-credentialing application.

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

Nondiscrimination Policy

Anthem will not discriminate against any applicant for participation in its programs or provider network(s) on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Anthem is required to include fields for the collection of practitioner race, ethnicity, and language on the application. However, Anthem does not use such reported to discriminate against a practitioner, and the application

includes a statement indicating the provision of such information is optional. Additionally, 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. Determinations as to which practitioners and providers require additional individual review by the Credentials Committee are made according to predetermined criteria related to professional conduct and competence. Credentials Committee decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Anthem will review denials and terms for consistency and lack of discrimination annually to identify discriminatory practices in the selection of practitioners. These reviews are documented in a report summary format by reason for the denial or term for initial denials, recredentialing, terminations, and off-cycle terminations. The reasons for denial or term include: not board certified, license/board action, malpractice, education/training, hospital privileges, criminal conviction, DEA, hospital action, insurance, work history gap, and federal sanctions. In addition, annually audits of practitioner complaints about credentialing shall be reviewed for evidence of alleged discrimination. Should discriminatory practices be identified through annual review or through other means, Anthem will take appropriate action(s) to track and eliminate those practices.

Initial Credentialing

Each practitioner or HDO must complete a standard application form deemed acceptable by Anthem when applying for initial participation in one or more of Anthem's networks or plan programs. For practitioners, the Council for Affordable Quality Healthcare (CAQH) ProView system is used. To learn more about CAQH, visit their web site at CAQH.org.

Anthem will verify those elements related to an applicants' legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the 120-calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards. The application attestation including work history verification must be dated and verified within 180 calendar days prior to the Credentials Committee decision.

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

A. Practitioners

Verification Element
License to practice in the state(s) in which the practitioner will be treating Members.
Hospital admitting privileges at a TJC, DNV NIAHO, CIHQ or ACHC accredited hospital, or a Network hospital previously approved by the committee.
DEA/CDS and state-controlled substance registrations • The DEA/CDS registration must be valid in the state(s) in which practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state.
Malpractice insurance
Malpractice claims history

Verification Element
Board certification or highest level of medical training or education
Work history
State or Federal license sanctions, exclusions or limitations
Medicare, Medicaid or FEHBP sanctions and exclusions
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 and exclusions

Re-credentialing

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

All applicable practitioners and HDOs in the Network within the scope of the Credentialing Program are required to be re-credentialed every three years unless otherwise required by applicable state contract or state regulations.

Health Delivery Organizations

New HDO applicants will submit a standardized application to Anthem for review. If the candidate meets Anthem screening criteria, the credentialing process will commence. To assess whether Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and re-credentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail below, in the "Anthem Credentialing Program Standards" section, all Network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, Anthem may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or a site survey performed by a designated independent external entity within the past 36 months for that HDO.

Credentialing Program Standards

Eligibility Criteria

A. Healthcare practitioners:

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

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

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

1. For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine ("ABPM"), or American Board of Oral and Maxillofacial Surgery (ABOMS) in the clinical discipline for which they are applying.
2. If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
3. If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.
4. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.
    a. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
        i. Previous board certification (as defined by one) of the following: ABMS, AOA, RCPSC, CFPC, ABFAS, ABPM, or ABOMS) in the clinical specialty or subspecialty for which they are applying which has now expired and a minimum of 10 consecutive years of clinical practice;
        ii. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty; or
        iii. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty and a faculty appointment of assistant professor or higher at an academic medical center and

teaching facility in Anthem's network and the applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.

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

5. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (DNV NIAHO), Center for Improvement in Healthcare Quality (CIHQ), a Accreditation Commission for Health Care (ACHC) accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network practitioner to provide inpatient care.
6. 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.
7. For Registered Dieticians (RD), the applicant must have completed a bachelor's degree at a US regionally accredited university or college and course work accredited or approved by the Accreditation Council for Education in Nutrition and Dietetics (ACEND) of the Academy of Nutrition and Dietetics. Completion of an ACEND accredited supervised practice program at a healthcare facility, community agency, or a foodservices corporation or combined with undergraduate or graduate studies. Typically, a practice program will run six (6) to twelve (12) months in length. Must have passed a national examination administered by the Commission on Dietetic Registration (CDR).

Criteria for Selecting Practitioners
New applicants (Credentialing):

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions.
2. Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote.
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies.
4. No evidence of potential material omission(s) on application.
5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Members.
6. No current license action.
7. No history of licensing board action in any state.
8. No current federal sanction or exclusion and no history of federal sanctions or exclusions (per System for Award Management (SAM), OIG and OPM report nor on NPDB report).
9. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled

substances, if applicable to their specialty in which they will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who treat Members in more than one state must have a valid DEA/CDS registration for each applicable state.

10. Initial applicants who voluntarily have no DEA/CDS registration, the exception listed below may apply or if the applicant can provide evidence that they have applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:
    a. It can be verified that this application is pending.
    b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber;
    c. The applicant agrees to notify Anthem upon receipt of the required DEA/CDS registration.
    d. Anthem will verify the appropriate DEA/CDS registration via standard sources.
        i. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90-calendar day timeframe will result in termination from the Network.

    Initial applicants who possess a DEA certificate in a state other than the state in which they will be seeing Anthem's Members will be notified of the need to obtain the additional DEA, unless the practitioner is delivering services in a telemedicine environment only and does not require a DEA or CDS registration in the additional location(s) where such telemedicine services may be rendered under federal or state law. If the applicant has applied for an additional DEA registration the credentialing process may proceed if all the following criteria are met:
    a. It can be verified that the applicant's application is pending; and
    b. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
    c. The applicant agrees to notify Anthem upon receipt of the required DEA registration; and
    d. Anthem will verify the appropriate DEA/CDS registration via standard sources; and
    e. The applicant agrees that failure to provide the appropriate DEA registration within a 90-day timeframe will result in termination from the network.

    Practitioners who voluntarily choose to not have a DEA/CDS registration if that practitioner certifies the following:
    a. controlled substances are not prescribed within their scope of practice; or in their professional judgement, the patients receiving their care do not require controlled substances and
    b. they must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances should it be clinically appropriate. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber; and
    c. DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than those aforementioned.
11. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions; or for Practitioners in specialties defined as requiring hospital privileges who practice solely in the outpatient setting, there exists a defined referral arrangement with a participating Practitioner of similar specialty at a participating hospital who provides inpatient care to members requiring hospitalization.

12. No history of or current use of illegal drugs or history of or current substance use disorder.
13. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
14. No gap in work history greater than six months in the past five years; however, gaps up to 12 months related to parental leave or immigration will be acceptable and viewed as Level I. All gaps in work history exceeding six months will require additional information and review by the Credentialing Department. A verbal explanation will be accepted for gaps of six to 12 months. Gaps in excess of 12 months will require written explanations. All work history gaps exceeding six months may be presented to the geographic CC if the gap raises concerns of future substandard Professional Conduct and Competence.
15. No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence.
16. A minimum of the past 10 years of malpractice claims history is reviewed.
17. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in Anthem's Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;
18. No involuntary terminations from an HMO or PPO.
19. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
    a. Investment or business interest in ancillary services, equipment or supplies;
    b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    c. Voluntary surrender of state license related to relocation or nonuse of said license;
    d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    e. Non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window.
    g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

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

Participation Criteria and Exceptions for Non-Physician Credentialing

The following participation criteria and exceptions are for non-MD practitioners. It is not additional or more stringent requirements, but instead the criteria and exceptions that apply for these specific provider types to permit a review of education and training.

1. Licensed Clinical Social Workers (LCSW) or other master level social work license type based on state licensing regulations:

a. Master or doctoral degree in social work.
b. If master's level degree does not meet criteria and practitioner obtained PhD degree as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. In addition, a doctor of social work will be viewed as acceptable.
c. Licensure to practice independently.

2. Licensed professional counselor ("LPC"), marriage and family therapist ("MFT"), licensed mental health counselor (LMHC) or other master level license type based on state licensing regulations:
    a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
    b. Master or doctoral degrees in divinity, masters in biblical counseling, or other primarily theological field of study do not meet criteria as a related field of study.
    c. Practitioners with PhD training as a clinical psychologist can be reviewed.
    d. Practitioners with a doctoral degree in one of the fields of study will be viewed as acceptable.
    e. Licensure to practice independently or in states without licensure or certification:
        i. Marriage & Family Therapists with a master's degree or higher:
            a. Certified as a full clinical member of the American Association for Marriage and Family Therapy (AAMFT), OR proof of eligibility for full clinical membership in AAMFT (documentation from AAMFT required).
        ii. Mental Health Counselors with a master's degree or higher:
            a. Provider applicant must be a Certified Clinical Mental Health Counselor (CCMHC) as determined by the Clinical Academy of the National Board of Certified Counselors (NBCC) (proof of NBCC certification required) or meet all requirements to become a CCMHC (documentation of eligibility from NBCC required).

3. Pastoral Counselors:
    a. Master's or doctoral degree in a mental health discipline.
    b. Licensed as another recognized behavioral health provider type (for example, MD/DO, PsyD, SW, RNCS, ARNP, and MFT, OR LPC) at the highest level of independent practice in the state where the practice is to occur OR must be licensed or certified as a pastoral counselor in the state where the practice is to occur.
    c. A fellow or diplomat member of the Association for Clinical Pastoral Education (ACPE) OR meet all requirements to become a fellow or diplomat member of the ACPE (documentation of eligibility of ACPE required).

4. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
    a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing.
    b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
    c. Certification by the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA) in psychiatric nursing, or the Pediatric Nursing Certification Board. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner; and

d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members.

5. Clinical Psychologists:
    a. Valid state clinical psychologist license.
    b. Doctoral degree in clinical or counseling, psychology or other applicable field of study.
    c. Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.
6. Clinical Neuropsychologist:
    a. Must meet all the criteria for a clinical psychologist listed in number 4 above and be Board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN);
    b. A practitioner credentialed by the National Register of Health Service Providers (National Register) in psychology with an area of expertise in neuropsychology may be considered; and
    c. Clinical neuropsychologists who are not board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
        i. Transcript of applicable pre-doctoral training;
        ii. Documentation of applicable formal one-year post-doctoral training (participation in CEU training alone would not be considered adequate);
        iii. Letters from supervisors in clinical neuropsychology (including number of hours per week); or
        iv. Minimum of five years' experience practicing neuropsychology at least ten hours per week.
7. Licensed Psychoanalysts:
    a. Applies only to practitioners in states that license psychoanalysts.
    b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Anthem Credentialing Policy (for example, psychiatrist, clinical psychologist, licensed clinical social worker).
    c. Practitioner must possess a valid psychoanalysis state license.
        1. Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
        2. Meet examination requirements for licensure as determined by the licensing state.
8. Process, requirements and Verification – Nurse Practitioners:
    a. The nurse practitioner (NP) applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
    b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the

education. If the licensing agency does not verify highest level of education, the education will be primary source verified in accordance with policy.

c. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
d. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Anthem procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.
e. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
    i. Certification program of the American Nurse Credentialing Center, a subsidiary of the American Nursing Association;
    ii. American Academy of Nurse Practitioners – Certification Program;
    iii. National Certification Corporation;
    iv. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (**Note**: CPN – certified pediatric nurse is not a nurse practitioner);
    v. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY; or
    vi. American Association of Critical Care Nurses Acute Care Nurse Practitioner Certification (ACNPC); ACNPC-AG – Adult Gerontology Acute Care. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review.
f. If the NP has hospital privileges, they must have hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the nurse practitioner will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.
g. The NP applicant will undergo the standard credentialing processes outlined in Anthem's Credentialing Policies. NPs are subject to all the requirements outlined in the Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for failure to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.

9. Process, Requirements and Verifications – Certified Nurse Midwives:
    a. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training and board certification.
    b. The required educational/training will be at a minimum that required for licensure as a registered nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur via primary source verification of the license, provided that state licensing agency performs verification of 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 CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered,

unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.

d. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Anthem procedures. If there are current adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
e. All CNM applicants will be certified by either:
    i. The National Certification Corporation for Ob/Gyn and neonatal nursing; or
    ii. The American Midwifery Certification Board, previously known as the American College of Nurse Midwifes.

   This certification must be active. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic CC.
h. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. In the event the CNM provides only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.
i. The CNM applicant will undergo the standard credentialing process outlined in Anthem's Credentialing Policies. CNMs are subject to all the requirements of the Credentialing Policies including (but not limited to): the requirement for CC review for Level II applicants, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the Network.

10. Process, Requirements and Verifications – Physician's Assistants (PA):
    a. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
    b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
    c. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
    d. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Anthem procedures. If there are in force adverse actions

against the DEA, the applicant will be notified and the applicant will be administratively denied.

e. All PA applicants will be certified by the National Commission on Certification of Physician's Assistants. This certification must be active. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy #8, as adopted or amended by each Anthem Health Plan and submitted for individual review by the CC.
f. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
g. The PA applicant will undergo the standard credentialing process outlined in Anthem's Credentialing Policies. PAs are subject to all the requirements described in these Credentialing Policies including (but not limited to): committee review of Level II files failing to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.

Currently Participating Applicants (Re-credentialing)

1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
2. Re-credentialing application signed date 180 calendar days of the date of submission to the CC for a vote;
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP. If, once a practitioner participates in Anthem's Plan programs or provider Networks, federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the practitioner will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Anthem's other credentialed provider Networks.
4. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to Members;
5. No new history of licensing board reprimand since prior credentialing review;
6. *No current federal sanction or exclusion and no new (since prior credentialing review) history of federal sanctions or exclusions (per SAM, OIG and OPM Reports or on NPDB report);
7. Current DEA/CDS registration and/or state-controlled substance certification without new (since prior credentialing review) history of or current restrictions;
8. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; or for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network practitioner of similar specialty at a Network HDO who provides inpatient care to Members needing hospitalization;
9. No new (since previous credentialing review) history of or current use of illegal drugs or substance use disorder;
10. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
11. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;

12. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
13. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
14. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
    a. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    b. Voluntary surrender of state license related to relocation or nonuse of said license;
    c. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    d. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    e. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window;
    f. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    g. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.
15. No quality improvement data or other performance data including complaints above the set threshold.
16. Re-credentialed at least every three years to assess the practitioner's continued compliance with Anthem standards.

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

    Note: the CC will individually review any credentialed Network practitioners and HDOs that do not meet one or more of the criteria for re-credentialing.

B. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Anthem may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past 36 months. If a HDO has satellite facilities that follow the same policy and procedures, Anthem may limit site visits to the main facility. Non-accredited HDOs are subject to individual review by the CC and will be considered for member access need only when the CC review indicates compliance with Anthem standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are re-credentialed at least every three years to assess the HDO's continued compliance with Anthem standards.

1. General Criteria for HDOs:
    1. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to Members. The license must be in good standing with no sanctions.
    2. Valid and current Medicare certification.
    3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the FEHBP. **Note**: If, once an HDO participates in Anthem's Plan programs or provider Networks, exclusion from Medicare, Medicaid or FEHBP occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Anthem's other credentialed provider Networks.
    4. Liability insurance acceptable to Anthem.
    5. If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if Anthem's quality and certification criteria standards have been met.
2. Additional Participation Criteria for HDO by Provider Type:

HDO Type and Anthem Approved Accrediting Agent(s)

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Acute Care Hospital	CIQH, TCT, DNV NIAHO, ACHC, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, ACHC, TJC
Birthing Center	AAAHC, CABC, TJC
Home Healthcare Agencies (HHA)	ACHC, CHAP, DNV NIAHO, TJC, TCT
Home Infusion Therapy (HIT)	ACHC, CHAP, TCT, TJC, NICA
Skilled Nursing Facilities/Nursing Homes	CARF, TJC
Durable Medical Equipment Suppliers	TJC, CHAP, TCT, ACHC, BOC, HQAA

Facility Type (Behavioral Healthcare)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	DNV NIAHO, ACHC, TJC, TCT
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, TJC, ACHC
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Use Disorder	ACHC, CARF, COA, DNV NIAHO, TJC
Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinics	CARF, CHAP, COA, ACHC, TJC
Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Use Disorder	CARF, DNV NIAHO, TJC
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Use Disorder	CARF, COA, DNV NIAHO, ACHC, TJC

Facility Type (Behavioral Healthcare - Rehabilitation)	Acceptable Accrediting Agencies
Acute Inpatient Hospital – Detoxification Only Facilities	TCT, DNV NIAHO, ACHC, TJC
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC
Outpatient Substance Use Disorder Clinics	CARF, TJC, COA,

Sanction Monitoring

To support certain Credentialing Standards between the re-credentialing cycles, Anthem has established an ongoing monitoring program. The Credentialing Department performs ongoing monitoring to help ensure continued compliance with Credentialing Standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the Credentialing Department will review periodic listings/reports monthly or 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 and State Medicare/Medicaid Reports
- Office of Personnel Management ("OPM")
- State licensing Boards/Agencies
- Member/Customer services departments
- Clinical Quality Management Department (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
- Other internal Anthem departments
- Any other information received from sources deemed reliable by Anthem.

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

Appeals Process

Anthem has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one or more of Anthem's Networks or Plan Programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Anthem may wish to terminate practitioners or HDOs. Anthem also seeks to treat network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating/denying participation in Anthem's Networks for professional conduct and competence reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB).

Additionally, Anthem will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is Anthem's intent to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one or more of Anthem's Networks or Plan Programs and those denials of request for initial participation which are reported to the NPDB that were based on professional conduct and competence considerations.

Immediate terminations may be imposed due to the practitioner's or HDO's license suspension, probation or revocation, if a practitioner or HDO has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, has a criminal conviction, or Anthem's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to Members. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for informal review/reconsideration or formal appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for informal review/reconsideration or formal appeal.

Reporting Requirements

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

Provider Reporting to Credentialing

Providers must notify Anthem Credentialing **within 14 calendar days** of any licensure action or investigation, Medicare or Medicaid adverse action, hospital privilege restriction or loss, National Practitioner Data Bank-reportable action, filed and served malpractice action, material reduction in professional liability coverage, or criminal conviction other than a minor traffic violation

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Chapter 11: Utilization Management & Prior Authorization

Authorization Requests and Time Frames

Department	Phone
Medi-Cal Utilization Management	**888-831-2246** Monday to Friday, 8 a.m. to 5 p.m.

Online Submission

Availity Essentials authorization application is the preferred method for digital submission of preauthorization requests. Providers can use the authorization application to request inpatient and outpatient medical or behavioral health services for Anthem members. Providers can also use the authorization application for inquiries on previously submitted requests regardless of how they were sent (phone, fax, ICR, or other online tools).

The Availity Essentials authorization application features allow the provider to:

- Initiate preauthorization requests digitally, eliminating the need to fax. The app allows detailed text, photo images and attachments to be submitted along with your request.
- Submit a notification of admission and request for continued stay review. The app allows submission of justification and attachments along with your request.
- Make inquiries on previously submitted requests via phone, fax, or other online tool.
- Have instant accessibility from anywhere including after business hours.
- Utilize the dashboard to provide a complete view of all UM requests with real-time status updates.
- Access real-time results for some common procedures with immediate decisions

Note: For an optimal experience with the ICR, use a browser that supports 128-bit encryption. This includes Microsoft Edge, Chrome, or Firefox.

To access the authorization application via the Availity Essentials platform, go to Availity.com > **Patient Registration** > **Authorizations and Referrals**.

Paper Forms

Providers can also request prior authorization by completing, printing, and faxing the appropriate Request for Pre-Service Review forms found at providers.anthem.com/california-provider/resources/forms or providers.anthem.com/california-provider > **Forms** > *Prior Authorizations*

Tips for filling out the forms and getting the fastest response to your authorization request:

- Fill out the form completely; unanswered questions typically result in delays.
- Print and fax the form to Medi-Cal Utilization Management at the numbers above.
- Do not store the form offline; access it online only. Anthem revises forms periodically, and outdated forms can delay your request.

Note: We do not reward practitioners and other individuals conducting utilization reviews for issuing denials of coverage or care. There are **no financial incentives** for UM decision-makers that encourage decisions resulting in underutilization. UM decision making is based only on appropriateness of care and service and existence of coverage.

Services that Do Not Require Prior Authorization

The following services **do not** require prior authorization (PA) or referrals for in-network providers:

- Emergency services
- Post-stabilization services (if medically necessary)
- Nebulizers
- Family planning/well woman checkup — members may self-refer to any Medicaid provider for the following services:
  - Pelvic and breast examinations
  - Lab work
  - Birth control
  - Genetic counseling
  - FDA-approved devices and supplies related to family planning (such as IUD)
  - HIV/STD screening
- Obstetrical care — no authorization required for in-network physician visits and routine testing
- Members not affiliated with an IPA or medical group do not require PA from Anthem for physician referrals to an in-network specialist for consultation or a nonsurgical course of treatment
- Standard X-rays and ultrasounds
- In-network speech therapy and occupational therapy

Services that Require Prior Authorization

Prior authorization ensures that services are based on medical necessity, are a covered benefit, and are provided by the appropriate providers.

Providers are responsible for verifying eligibility and ensuring that our Utilization Management (UM) department has conducted preservice reviews for elective nonemergency and scheduled services before rendering those services.

Prior authorization must be obtained for all out-of-network services or services rendered outside of an emergency room or urgent care setting.

Some Anthem members are assigned to delegated medical groups or IPAs. Providers should contact the member's assigned medical group to confirm the need for authorization before elective services. Services requiring prior authorization include but are not limited to:

- Air ambulance (nonemergent)
- Behavioral health services (except psychiatric assessments and mental health assessments by non-physician; for more information, see **Chapter 5: General Benefits**)
- Cardiac and pulmonary rehabilitation
- Cosmetic procedures
- Dental (medically necessary facility and anesthesia services)
- Dialysis services
- Durable medical equipment and disposable supplies
- Experimental and investigational services
- Genetic testing
- Home healthcare services
- Hospice
- Chemotherapy
- Inpatient hospital services:
    - Nonurgent inpatient admissions
    - Long-term acute care facility (LTAC)
    - Inpatient skilled nursing facility (SNF)
    - Rehabilitation facility admissions
    - Newborn stay beyond mother
- Laboratory tests (specific)
- Out-of-network referrals to specialists
- Outpatient surgical services (delivered in an ambulatory surgical center or outpatient hospital)
- Certain preferred medications and all nonpreferred medications may require PA (call Medi-Cal Rx **800-977-2273** or fax CA DHC standard PA form to Medi-Cal Rx fax number **800-869-4325**)
- Specialty injectable medications such as Synagis and Botox require PA through Anthem (Contact the UM department at **888-831-2246** for more information.)
- Radiology services including MRA, MRI, PET, and CT scans
- Spinal surgeries:
    - Artificial disc placement
    - Artificial disc removal
    - Artificial disc replacement
    - Decompress spinal cord
    - Low back disc surgery
    - Lumbar spine fusion
    - Remove spinal lamina
    - Vertebral corpectomy
    - Major organ transplants (for members 21 years of age and older
    - For a more comprehensive list of services requiring prior authorization, go to *Prior Authorization and Preservice Review* on the **Provider Resources** page of our website at providers.anthem.com/CA.

Keep in mind, obtaining a prior authorization is not a guarantee of payment. Health plan benefits have policy exclusions, limits, waivers and eligibility standards that apply when care is received.

Authorization Criteria

Authorizations are based on:

- Benefit coverage
- Established criteria
- Community standards of care

The decision-making criteria used by the UM team is evidence-based and consensus-driven. We periodically review criteria and update when standards of practice or technology change. We involve practicing physicians in these updates and notify providers of changes through our provider bulletins.

These criteria are available to members, physicians, and other healthcare providers upon request by contacting the appropriate UM department using the contact numbers at the beginning of this chapter.

Based on sound clinical evidence, the UM team provides the following service reviews:

- Prior authorizations
- Continued stay reviews
- Post-service clinical claims reviews

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

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

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

- Approval, modification, denial

If you disagree with a UM decision and want to discuss the decision with the physician reviewer, call:

- Peer-to-peer: **877-496-0071**

Requesting Authorization

When authorization of a healthcare service is required, contact Anthem for questions or requests including:

- Routine, nonurgent care reviews
- Urgent or expedited preservice reviews
- Urgent continued stay reviews

Providers can also fax the UM team and include requests for:

Request Type	Fax Number
Preservice reviews	**800-754-4708**
Nonurgent continued stay reviews	**866-333-4826**

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

All providers including physicians, hospitals and ancillary providers are required to provide information to support their request to the UM department. Physicians are also encouraged to review their utilization and referral patterns.

When contacting the Utilization Management department to request a preservice review or report a medical admission, please provide the following information:

- Member name and identification (ID) number
- Diagnosis with the ICD-10 code
- Procedure with the CPT code
- Date of injury or hospital admission and third-party liability information (if applicable)
- Facility name (if applicable)
- Primary care provider (PCP) name
- Specialist or attending physician name
- Clinical justification for the request
- Level of care
- Lab tests, radiology, and pathology results
- Medications
- Treatment plan including time frames
- Prognosis
- Psychosocial status
- Exceptional or special needs issues
- Ability to perform activities of daily living
- Discharge plans

Additional information to have ready for the clinical reviewer includes but is not limited to:

- Office and hospital records
- History of the presenting problem
- Clinical exam
- Treatment plans and progress notes
- Information on consultations with the treating practitioner
- Evaluations from other healthcare practitioners and providers
- Photographs
- Operative and pathological reports
- Rehabilitative evaluations
- Printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics and information
- Information from responsible family members

Requests with Insufficient Clinical Information

When the UM team receives requests with insufficient clinical information, we will contact the provider with a request for the information reasonably needed to determine medical necessity.

We will make at least one attempt to contact the requesting provider to obtain additional information. If no response is received within the specified time frame of receipt of the request, we will send a Notice of Action: Denial – Requested Information Not Received letter to the member and provider.

Pre-Service Review Time frame

For routine, nonurgent requests, the UM team will complete preservice reviews within seven calendar days from receipt of information reasonably necessary to make a decision, not to exceed 14 calendar days from the date of request.

Requests that do not meet criteria are sent to the physician advisor or medical director for further review.

Providers will be notified of denials or deferrals by phone or fax within one business day from the date of the decision.

Providers and members will be sent a written notification of denials or deferrals within two business days from the date of the decision.

Urgent Preservice Requests

For urgent preservice requests, the UM team will complete the preservice review within 72 hours from the receipt of the information reasonably necessary to make a decision, not to exceed 14 calendar days from receipt of the request.

Providers are responsible for contacting Anthem to request preservice reviews for both professional and institutional services. However, a hospital or ancillary provider should always contact Anthem to verify preservice review status for all nonurgent care before rendering services.

An urgent request is any request for medical care or treatment that cannot be delayed because delay would result in one of the following:

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

Emergency Medical Conditions and Services

Anthem does **not** require a prior authorization (PA) for treatment of emergency medical conditions. In the event of an emergency, members can access emergency services 24 hours a day, 7 days a week.

In the event that the emergency room visit results in the member's admission to the hospital, providers must contact Anthem within 24 hours or one business day if the member was admitted on a weekend or holiday.

Members who call their PCP's office reporting a medical emergency (whether during or after office hours) are directed to dial 911 or go directly to the nearest hospital emergency department. All nonemergent conditions should be triaged by the PCP or treating physician with appropriate care instructions given to the member.

Emergency Stabilization and Post-Stabilization

The emergency department's treating physician determines the services needed to stabilize the member's emergency medical condition. After the member is stabilized, the admitting or the emergency department's physician must contact Anthem for authorization of further services. Anthem's Post Stabilization phone line is available 24 hours a day, 7 days a week at **844-776-9504.** If Anthem does not respond within 30 minutes, the needed services will be authorized.

If the member is a part of a Full or Dual Risk Group, please contact the Medical Group noted on the back of the ID card to report a Post Stabilization admission.

All providers who are involved in the treatment of a member share responsibility in communicating clinical findings, treatment plans, prognosis, and the psychosocial condition of such member with the member's PCP to ensure effective coordination of care.

Continued Stay Review

Hospital Inpatient Admissions

Hospitals must notify the UM department of inpatient medical admissions within 24 hours of admission or by the next business day. Behavioral health admissions are the responsibility of the member's County Mental Health Plan.

When a member's hospital stay is expected to exceed the number of days authorized during preservice review or when the inpatient stay did not have preservice review, the hospital must contact Anthem for continued stay review.

Anthem requires clinical reviews on all members admitted as inpatients to:

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

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

- Facilities reporting admissions
- Providers reporting admissions
- Members or their representatives reporting admissions
- Claims submitted for services rendered without authorization
- Preservice authorization requests for inpatient care

The Anthem UM team will complete continued-stay inpatient reviews within three calendar days of the receipt of necessary clinical information to make a determination, not to exceed 14 calendar days, consistent with the member's medical condition. Anthem UM staff will request clinical information from the hospital on the same day Anthem is notified of the member's admission and/or continued stay.

Clinical Information for Continued Stay Review

If after notification of an inpatient admission, there is insufficient clinical information to determine medical necessity, the provider is contacted with a request for the clinical information reasonably necessary to determine medical necessity. Evidence-based criteria are used to determine medical necessity and the appropriate level of care.

If the information meets medical necessity review criteria, we will approve the request within three calendar days from the time the information is received. Requests that appear to not meet medical policy guidelines will be sent to the physician adviser or medical director for further review.

Anthem will notify providers within 24 hours of the decision and send written notification of any denial or modification of the request to the member and requesting provider.

Denial of Service

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

- Procedures
- Hospitalization
- Equipment

When a request is determined to be not medically necessary, the requesting provider will be notified of the following:

- Decision
- Process for appeal
- How to reach the reviewing physician for peer-to-peer discussion of the case

Providers can contact the physician clinical reviewers to discuss any UM decision by calling the UM department.

Post-service Clinical Claims Review

Post-service clinical claims review determines the medical necessity and/or level of care for services that were provided without getting required preservice or continued stay authorization. For inpatient admissions where no notification was received and no patient days were authorized, facilities are required to submit a copy of the medical record with the claim.

Referrals and Second Opinions

Referrals to Specialists

The UM team is available to assist providers in accessing a network specialist. Review the following when referring members:

- PA is **not** required if referring a member not affiliated with an IPA or medical group to an in-network specialist for consultation or a nonsurgical course of treatment.
- PA **is** required when referring to an out-of-network specialist.
- Authorization from UM is **not** required for Medi-Cal members who self-refer for sensitive services (see Chapter 4: General Benefits), even if services are rendered out-of-network.

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

Note: Obtain a PA approval before referring members to an out-of-network provider. For out-of-network providers, Anthem requires PA for the initial consultation and each subsequent service provided.

PCP Referrals

PCPs coordinate and make referrals to specialists, ancillary providers, and community services. Providers should refer members to network facilities and providers. When this is not possible, providers should follow the appropriate process for requesting out-of-network referrals.

Note: Specialty referrals to in-network providers do not require PA from Anthem; however, please check with the member's medical group to confirm.

All PCPs are expected or responsible to:

- Help members schedule appointments with other providers and health education programs.
- Track and document appointments, clinical findings, treatment plans and care received by members referred to specialists or other healthcare providers to ensure continuity of care.
- Screen and evaluate procedures for detection and treatment of or referral for
- Coordinate with the local tuberculosis (TB) control program to ensure that all members with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy (DOT).
- Refer members to specialists or specialty care, behavioral health services, health education classes and community resource agencies including the California Department of Developmental Services regional centers, which are responsible for

any known or suspected behavioral health problems and disorders.
- Refer members to specialists or specialty care, behavioral health services, health education classes and community resource agencies, when appropriate.
- Coordinate with the Woman, Infants and Children (WIC) program to provide medical information necessary for WIC eligibility determinations such as height, weight, hematocrit or hemoglobin.

the Early Start Program (ESP) for children up to 3 years of age with developmental disabilities. Community resources also include the California Children's Services (CCS).

Out-Of-Network Referrals

Anthem recognizes that there may be instances when an out-of-network referral is justified. Medi-Cal's Utilization Management team will work with the PCP to determine medical necessity; after that, out-of-network referrals will be authorized on a limited basis. The UM department may be contacted at:

- Medi-Cal Utilization Management: **888-831-2246** Monday to Friday, 8 a.m. to 5 p.m.
- Medi-Cal Utilization Management fax: **866-333-4827** Monday to Friday, 8 a.m. to 5 p.m.

Self-referable Services

Members may self-refer to any of the following services without PA if their benefits allow:

- Emergency services
- Annual well-woman exam (in-network only)
- Diagnosis and treatment of sexually transmitted diseases (STD)
- Family planning services (services to prevent or delay pregnancy)
- Basic prenatal services (in-network only)
- Testing and counseling for Human Immunodeficiency Virus (HIV)

Members associated with capitated medical groups must self-refer to services within the group.

Note: Self-referable services may be rendered by a willing provider, even a provider without a contract, unless limited by state of federal regulation. We reimburse contracted providers according to the provider's contract; noncontracted providers are reimbursed at reasonable and customary rates.

Second Opinions

Second opinions are covered services and offered at no cost to Anthem members. The following are important guidelines regarding second opinions:

- The second opinion must be given by an appropriately qualified healthcare professional.
- The second opinion must come from a provider of the same specialty.
- The secondary specialist must be within the Anthem network and may be selected by the member. When there is no network provider who meets the specified qualifications, Anthem may authorize a second opinion by a qualified provider outside of the network upon request by the member or provider.

Transition and Discharge Planning

Anthem assists with coordinating care transitions and discharge planning in partnership with facilities. For assistance with care transitions, call **805-713-0845**.

Delegated Utilization Management

The Utilization Management (UM) process for Medi-Cal Members is primarily delegated to the PMG/IPA. UM that is not delegated to the PMG/IPA is retained by Anthem or an Anthem affiliate.

Most aspects of in-area healthcare for Anthem Medi-Cal Members are reviewed and provided by Medi-Cal PMGs/IPAs. This includes in-area emergency care, as well as care that must be provided by non-network providers due to the group's inability to provide care in-network.

The following care is not delegated to PMG/IPA (see the appropriate referenced sections) for UM:

- Behavioral Health
- Experimental/ Investigational Procedures
- Out-of-Area/Out-of-State Emergency Inpatient Admissions
- Transgender Services
- Major Organ Transplant surgery and care six months post-transplant

Anthem delegates UM to the PMGs/IPAs that demonstrate compliance with Anthem established standards for the UM function. Care providers associated with these delegated PMGs/IPAs may use the PMG/IPA's medical management office and protocols for all authorizations for which the PMG/IPA is delegated. The PMG/IPA's UM protocols must be in alignment with those of Anthem's Medical Policy and Clinical Guidelines. The delegated PMG/IPA's UM protocols and procedures must comply with all applicable accreditation, State, and Federal regulatory requirements. Policies must include established UM denial system controls policies and processes to protect and monitor data from unauthorized modification.

Admission, Discharge, Transfer (ADT) Data

In accordance with CMS Interoperability and Patient Access Final Rule (CMS-9115-F) and the CalHHS Data Exchange Framework (DxF), general acute care hospitals and emergency departments must send admission, discharge, or transfer (ADT) notifications to other organizations that have signed the DxF Data Sharing Agreement if requested in advance of the admission, discharge, or transfer event (ADT Event).

Participating facilities are required to send and accept notification of ADT events unless prohibited by applicable law. They must be HIPPA-compliant, acceptable format, and supported by the requesting participant.

Chapter 12: Care Management & Health Programs

Care Management Contacts

Contact	Fax Number
Care Management department	888-334-0870
Care Management fax	866-333-4827
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.	

Anthem care management is a process that emphasizes teamwork to assess, develop, implement, and coordinate treatment plans to optimize our members' healthcare benefits and promote quality outcomes.

Members referred to the Care Management team may be identified by disease, condition, or high utilization of services.

Referral Process

Anyone may refer members to Care Management by phone, faxing, or emailing a Care Management Referral form to the Care Management team.

The Medi-Cal Case Management Referral form is located in the General Forms Library on the *Provider Resources* page of our website at providers.anthem.com/california-provider/resources/forms.

A care manager will respond to a referral request within three business days.

Role of the Care Manager

The care manager, through discussions with the member, the member's representative and/or providers, collects data and analyzes information about current and potential healthcare needs for the purpose of developing a treatment plan. The care manager's role also includes the responsibility to:

- Facilitate communication and coordination within the healthcare team, member, or member representative.
- As a single point of contact the Case manager educate the member and providers, on the healthcare team, about care management programs, community resources, benefits, and all related topics so that informed decisions can be made.
- Encourage appropriate use of medical facilities and services with the goal of improving quality of care.

The Care Management team includes experienced and credentialed Registered Nurses and Social Workers, some of whom are **certified case managers** (CCMs). The team also uses Community Health Workers to reach members in the community or in their home. The Care Management multidisciplinary team holistically allows us to address not only our members' medical needs, but also their emotional and social determinants of health.

To support our diverse membership, the Care Management team is able to provide culturally and linguistically appropriate community-based referrals as needed.

Interpreter services are also available to support the care management process at no cost to the member.

Provider Responsibility

Providers have the responsibility of participating in care management, sharing information, and facilitating the process by:

- Referring members who could benefit from care management.
- Sharing information as soon as possible including any complex healthcare needs identified during the Initial Health Appointment (IHA).
- Collaborating with Care Management staff on an ongoing basis.
- Recommending referrals to specialists as required.
- Monitoring and updating the care plan to promote healthcare goals.
- Notifying Care Management if members are referred to services provided by the state or some other institution not covered by the Anthem agreement.
- Coordinating county or state-linked services such as public health, behavioral health, schools, and waiver programs. The provider may call Care Management for additional assistance.

Procedures

When a member has been identified as having a condition that may require care management, the care manager contacts the referring provider and member for an initial assessment.

With the involvement of the member, the member's representative and the provider, the care manager develops an individualized care plan. That plan may involve coordinating services with public and behavioral health departments, schools, and other community health resources.

The care manager periodically reassesses the care plan to monitor the following:

- Progress toward goals
- Necessary revisions
- New issues that need to be addressed to help ensure that the member receives the support needed to achieve care plan goals

Once goals are met or Care Management is collaboratively determined to be completed, or in cases where the member becomes unable to continue, the care manager closes the member's case.

Members Eligible for Specialized Services

The Care Management team works closely with providers to ensure continuity and coordination of care for our members who are eligible for linked and state-administered services. These services may come from the following:

- California Children's Services (CCS)
- County Behavioral Mental Healthcare
- County supported substance use disorder treatment
- Early Start/Early Intervention
- Regional Centers

Although these agencies provide specialized services for our members, PCPs remain responsible for providing or arranging for the provisions of all necessary and preventive medical services.

Potential Referrals

Providers, nurses, social workers, and members or their representatives may request care management services. Examples of appropriate referrals include:

- Children or adults with special healthcare needs requiring coordination of care and carved out services such as certain mental health services
- HIV/AIDS
- Chronic illnesses such as asthma, diabetes, heart failure or end-stage renal disease
- Complex or multiple care needs such as multiple trauma or cancer
- Frequent hospitalizations or emergency room utilization
- Hemophilia, sickle cell anemia, cystic fibrosis, cerebral palsy
- High-risk pregnancies (in other words, teen pregnancies, history of pre-term birth)
- Potential transplants
- Seniors and persons with disabilities (SPD)
- Individuals who may need or are receiving services from out-of-network providers or programs
- Enhanced Care Management
- Transitional Care Services when moving from one level of care in a facility to another.

Transitioning Disenrollees

The care manager is available to assist a member that requests help to transition to another health plan. Providers may contact Care Management if assistance is needed.

Provider Assessment of Pregnancy Risk

The PCP or prenatal care physician should assess all pregnant members for high-risk indicators during the initial prenatal care visit. For all pregnant members, the provider needs to:

- Complete a Pregnancy Notification Report and submit it to **855-410-4451**
- Refer members to prenatal education, childbirth education and breastfeeding classes; members can register by calling our Customer Care Centers.
- Document all referrals in the member's medical record.
- Schedule the member for a postpartum visit.

For additional information, go to the *Prenatal Resources* page of our website at providers.anthem.com/california-provider/patient-care/pregnancy-and-maternal-child-services.

Continuity of Care

Anthem provides continuity of care (COC) 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, as long as continuity of care requirements are met. Members who meet the COC requirements may request COC for up to 12 months after the enrollment date with Anthem if a pre-existing relationship exists with that provider.

Continuity of care requirements include:

1. The member has seen the provider in the last year for a non-emergent visit
2. The provider is willing to accept Anthem's contract rates or Medi-Cal FFS rates;
3. The provider meets Anthem's applicable professional standards and has no disqualifying quality of care issues; and
4. The provider is a California State Plan approved provider.
5. The provider supplies Anthem with all relevant treatment information, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.

Continuity of care protections extend to primary care providers, specialists, and select ancillary providers, including physical therapy, occupational therapy, respiratory therapy, behavioral health treatment (BHT), speech therapy providers, and durable medical equipment (DME).

Continuity of care protections do not extend to all other ancillary providers such as radiology, laboratory, dialysis centers, non-emergency medical transportation (NEMT), non-medical transportation (NMT), other ancillary services, and non-enrolled Medi-Cal providers.

All new enrollees receive a Member Services Guide/Evidence of Coverage (EOC) and membership information in their enrollment packets. This provides information regarding members' rights to request continuity of care. Anthem members are also notified of their right to request continued access to care whenever their provider terminates (through their member notification letter), or during a time of transition into Anthem from a Fee-for-Service (FFS) Medi-Cal program.

Scheduled Specialist Appointments: At the member, provider or authorized representatives request, Anthem will allow transitioning members to keep authorized and scheduled specialist appointments with OON providers when COC has been established and the appointments occur during the 12-month COC period. cc

Qualifying Condition: A medical condition that may qualify a member for continued access to care and continuity of care. These conditions include but are not limited to:

States of transition may be any of the following:

- The member is newly enrolled in Medi-Cal Managed Care from Medi-Cal Fee-for-Service
- The member is transitioning from another health plan to Anthem
- The provider's contract terminates
- Medical exemption request (MER) denials (Anthem will notify delegates (PMGs/IPAs) if their team has a COC request to review due to DHCS denying a member's request for exemption from enrolling in a Managed Care Plan)
- Other COC requests that are not MER denials
- Covered California to Medi-Cal Transition: Populations that undergo a mandatory transition from Covered California to Medi-Cal Managed Care coverage at Anthem due to the Covered California yearly coverage renewal determination or changes in member's eligibility circumstances that may occur at any time throughout the year. Anthem will ask these members if there are upcoming health appointments or treatments scheduled and assist them. If members request COC, Anthem will initiate the process. Anthem will contact new members by their preferred method of communication, no later than 15 days after enrollment and make a good faith effort to honor active prior treatment authorizations with a network provider and/or establish COC. Anthem will honor any active prior treatment authorizations for 90 days for services that are covered under its contract. After 90 days, the active authorization remains in effect for the duration of the treatment authorization or until completion of a new assessment, whichever is shorter.

A terminated provider or provider group who actively treats members must continue to provide and be compensated under the terms of the Agreement for Medical Services provided to members who are under the care of provider or provider group at the time of that termination, until the services being rendered to that member are completed or reasonable and medically appropriate provision is made for the assumption of such services by another participating MCP provider.

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 helps coordinate care when a provider's contract has been discontinued to ensure a smooth transition to a new provider.

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

- Consultations
- Prior authorizations
- Referrals to specialists
- Treatment plans

All providers share responsibility in communicating clinical findings, treatment plans, prognosis and the member's psychosocial condition as part of the coordination process.

Anthem will accept COC requests from members, providers, or authorized representative. Requests will be accepted over the telephone, according to the requestor's preference, and does not require the requestor to complete and submit a paper or online form if the requester prefers to make the request by telephone.

To make a continuity of care request, providers can submit the Preservice Review form to the Utilization Management department (fax number: **800-754-4708**). Utilization management nurses review requests for continuity of care and facilitate continuation with the current provider until a short-term regimen of care is completed or the member transitions to a new practitioner. For members assigned to a delegated group, requests for continuity of care for certain services are submitted to and reviewed by the delegated group.

Note: Anthem may 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 can appeal the decision by following the procedures **in** Chapter 17: Grievances, Appeals, Disputes of this manual. Reasons for continuity of care denials include but are not limited to the following:

- Continuity of care is not available with the terminating provider.
- 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 a covered benefit.
- Services rendered are covered under a global fee.
- Treating provider is currently contracted with our network.

Anthem and our subcontracted delegates will begin to process non-urgent requests within five working days following the receipt of the Continuity of Care request. Additionally, each Continuity of Care request will be completed within the following timelines from the date the Anthem received the request:

- 30 calendar days for non-urgent requests;
- 15 calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or
- As soon as possible, but no longer than three calendar days for urgent requests (for example, there is identified risk of harm to the member).

Member Notifications

Anthem and our subcontracted delegates will provide acknowledgment of the continuity of care requests within the timeframes specified below, advising the members that the continuity of care request has been received, the date of receipt, and the estimated timeframe for resolution.

- For non-urgent requests, within seven calendar days of the decision.
- For urgent requests, within the shortest applicable timeframes that is appropriate for the members condition, but no longer than three calendar days of the decision.

Mandatory Continuity of Care (COC) Reporting

Complete, accurate, reasonable, and timely reporting of COC Other cases and COC MER Denial cases are required monthly per CA Dept of Health Care Services (DHCS) through their Managed Care Program Data Improvement Project (MCPD).

DHCS considers a case Continuity of Care when a member wishes to continue seeing an out of network provider when they first transition over to Anthem from a Medi-Cal direct FFS or another health plan. To be eligible for COC, the member needs to have seen the requested provider within the last 12 months prior to the transition.

Note: this includes any Continuity of Care requests for Gender Affirming Care. Anthem has a Member Nondiscrimination Policy, see Chapter 3: Member Eligibility, the Member Nondiscrimination section of this manual for more details.

Providers contracted with a PMG or IPA must ensure they are providing the PMG/IPA with Continuity of Care requests data. Therefore, the PMG or IPA can submit the data to Anthem monthly as required by DHCS.

Medi-Cal PMGs and IPAs must follow Anthem's MCPD Delegate Companion Guide for reporting requirements.

Mandatory Out-of-network (OON) Reporting

Complete, accurate, reasonable, and timely reporting of Out-of-Network (OON) cases are required monthly per CA Department of Health Care Services (DHCS) through their Managed Care Program Data Improvement Project (MCPD). Any request to see a provider outside of Anthem's network is an OON request even if that request is to continue seeing a provider that was recently terminated. Per DHCS, for reporting purposes these cases should be reported as OON. Continuity of Care (COC) is reserved for reporting newly transitioned members' care.

An OON case also refers to anytime the member requests to see a provider outside the network. There are no exclusions made based on the OON specialty requested. This can be a request for inpatient, outpatient, hospital, or other facilities such a skilled nursing.

Note: this includes any Out-of-Network requests for Gender Affirming Care. Anthem has a Member Nondiscrimination Policy, see Chapter 3: Member Eligibility, the Member Nondiscrimination section of this manual for more details.

Providers contracted with a PMG or IPA must ensure they are providing the PMG/IPA with Continuity of Care requests data. Therefore, the PMG or IPA can submit the data to Anthem monthly as required by DHCS.

Medi-Cal PMGs and IPAs must follow Anthem's MCPD Delegate Companion Guide for reporting requirements.

For more information on continuity of care, review DHCS' website at Continuity of Care for Medi-Cal Managed Care Members.

Condition Care Programs

Providers can refer a member to the program by calling Condition Care (CNDC) at **888-830-4300**:

- Hours of operation are 8:30 a.m. to 5:30 p.m. local time. Confidential voicemail is available 24 hours a day.
- CNDC program content is located at providers.anthem.com/california-provider/patient-care/condition-care.
- Referral form: providers.anthem.com/docs/gpp/california-provider/CA_CAID_Forms_DiseaseManagementReferralForm.pdf

Condition Care

Condition Care (CNDC) services are based on a system of coordinated care management interventions and communications designed to help physicians and other healthcare professionals manage members with chronic conditions.

Our services include:

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

Our condition care programs include:

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

In addition to our condition-specific condition care programs, our member-centric, holistic approach also allows us to assist members with managing their weight and/or smoking cessation 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 primary and ancillary providers regarding patient status
- Nine of our Condition Care program conditions are NCQA-accredited and incorporate outreach, education, care coordination and follow-up to improve treatment self-care.

Who Is Eligible

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

As a valued provider, we welcome your referrals of patients who can benefit from additional education and condition care 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 number of gaps in care/needs.

Members enrolled in Condition Care programs receive education on self-management concepts, which include primary prevention, coaching related by healthy behaviors and compliance/monitoring as well as case/care management for high-risk members. Providers are given telephonic and/or written updates regarding patient status and progress.

CNDC Provider Rights and Responsibilities

You have the right to:

- Obtain information about our organization's services, staff qualifications and any contractual relations.
- Decline to participate in or work with the organization's programs and services on behalf of their patients
- Be informed of how the organization coordinates interventions with care plans for individual members
- Know how to contact the case manager responsible for managing and communicating with their patients
- Be supported by our organization when interacting with members to make decisions about their healthcare
- Receive courteous and respectful treatment from our organization's staff
- Communicate complaints to the organization.

CNDC and our programs do not advertise, market or promote specific products or services to members or providers. CNDC and our programs do not have any financial ownership arrangements with anyone who advertises, markets or provides the goods and services we offer.

Hours of Operation

Our CNDC case managers are registered nurses. They are available: 8:30 a.m. to 5:30 p.m. local time. Confidential voicemail is available 24 hours a day. The NurseLine is available for our members 24 hours a day, 7 days a week.

Contact Information

You can call a CNDC team member at **888-830-4300:**
CNDC program content is located at providers.anthem.com/california-provider/patient-care/condition-care.

Members can obtain information about CNDC program at mss.anthem.com/california-medicaid or by calling **888-830-4300**.

Health Service Programs

Maternal Child Services: New Baby, New Life℠

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

When it comes to pregnancy, we are committed to healthy outcomes or our members and their babies. That's why we encourage all 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 case management support for members with the highest risk.
- Care coordination for those members who may need a little extra support.
- Digital perinatal educational tools
- Information on community resources
- Incentives to encourage members to keep up with checkups.

As part of the program, perinatal members have access to a digital 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 pregnant, they will receive an invitation to access this program by downloading the app. After the app is installed and the member registers, they are asked to complete a pregnancy screener. The answers provided in the screener allow us to assess their pregnancy risk.

After the 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 supplemental tool to extend our health education outreach. The goal of the expanded outreach is to ensure education is available to all perinatal members and to assist us 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 completed forms to **855-410-4451**.

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 is 15 years of age or over
- If the member is not pregnant, select no and submit to continue to the E&B response screen.
- If the member is pregnant, select yes and submit. You will be prompted to enter additional dates if known:
  - Estimated Due Date
  - First prenatal appointment date
- When YES is selected, the maternity data entered is saved for this member.
- After submitting your answer, the E&B response screen will display.

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

For more information about the New Baby, New Life program or the digital app, reach out to Medi-Cal Customer Care Center at:

Location	Customer Care Center Phone
L.A. County	**888-285-7801** Monday to Friday, 7 a.m. to 7 p.m.
All Other Counties	**800-407-4627** Monday to Friday, 7 a.m. to 7 p.m.
TTY	**888-757-6034** (**TTY 711**)

As of July 1, 2019, obstetric providers are required to screen or offer to screen women for perinatal mood disorders.

The American College of Obstetricians and Gynecologists has outlined depression screening instruments to be used during the pregnancy and postpartum periods including:

- Edinburgh Postnatal Depression Scale (EPDS).
- Patient Health Questionnaire 9.
- Providers are asked to document screening in the medical record.
- For referrals to care coordination for behavioral health, call **855-473-7902** and select **1** then option **2** to request care coordination.

Chapter 13: Quality Management

The Anthem longstanding goal has been continuous, measurable improvement in our delivery of quality healthcare. Following federal and state guidelines, we have a Quality Management (QM) program to:

- Objectively and systematically monitor and evaluate the quality, safety and appropriateness of medical care and service offered by the health network.
- Identify and act upon opportunities for improvement.

The QM program includes focused studies and reviews that measure quality of care in specific clinical and service areas. All providers are expected to participate and cooperate with Anthem in any reasonable internal and external quality assurance, utilization review, continuing education and other similar programs established. Participation in these activities is part of our mutual goal of providing responsive and cost-effective healthcare that improves our members' lives.

Quality Performance Requirements

Anthem participates in national and state evaluations that measure the quality performance of our plan and providers. The National Committee for Quality Assurance (NCQA) provides a national annual report of their Healthcare Effectiveness Data and Information Set (HEDIS) rankings across health plans.

This report is a tool used by more than 90% of America's health plans to rate performance across a wide spectrum of care and service areas including clinical performance and member satisfaction. The HEDIS results can also be used by anyone to make comparisons before choosing a health plan. Anthem uses the HEDIS data to identify areas for improvement and shares the results with providers.

The California Department of Health Care Services (DHCS) has selected a set of quality measures that apply to all Medi-Cal Managed Care Plans (MCPs). These quality measures are known as the Managed Care Accountability Set (MCAS), Anthem is required to perform at the least as well as 50% of all Medicaid plans in the United States (50th percentile).

This requirement is known as the Minimum Performance Level (MPL), and it applies to all measures that are a part of the MCAS. When the MPL is not met for any measure within the MCAS, DHCS may impose the following actions on Anthem:

- Corrective Action Plans
- Sanctions
- PDSA Participation

All applicable Anthem network providers, including safety net clinics, independent practitioners, Physician Medical Groups (PMGs), Independent Physician Associations (IPAs), Public Hospitals and other health systems are required to meet the MPL for all measures within the DHCS selected MCAS.

Anthem reserves the right to and may impose sanctions on any provider that does not meet the MPL (See Chapter 9: Administrative Procedures.).

- Suspending auto-assignment of members that didn't choose a provider
- Freezing panels for assignment of any new members
- Withholding 5-15% of capitation payments at Anthem discretion
- Terminating contracts for material breach or according to other termination provisions

For more information about the most updated Managed Care Accountability Set (MCAS) measures go to the Department of Health Care Services (DHCS) Medi-Cal MCAS site at dhcs.ca.gov/data-statistics/dhcs-data-statistics-reports/accountability-sets.

Quality Management Program Documentation

The QM 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 QM program includes but is not limited to the monitoring and evaluation of:

- Care and service provided in all health delivery settings
- Chronic disease management and prevention programs
- Child/Adolescent Care
- Dyadic Services and Family Therapy Benefit
- Blood Lead Screening Program
- Initial Health Appointment
- Maternity management programs
- Coordination of medical care
- Community health
- Service quality
- Case management of members with complex health conditions
- Facility site review
- Medical record review
- HEDIS medical record review
- Provider/member satisfaction
- Member/patient safety
- Utilization management
- Behavioral health programs
- Pharmacy and therapeutics
- Clinical practice guidelines
- Over and under utilization

Anthem develops an annual work plan of quality improvement activities based on the results of the previous year's QM program evaluation. QM program revisions are made based on outcomes, trends, accreditation, contractual and regulatory standards and requirements, and overall satisfaction with the effectiveness of the program.

The QM program evaluation is the reporting method used to evaluate the progress of each provider's quality performance and results of planned activities toward established goals. Providers support the activities of the QM program by:

- Participating in the facility and medical record audit process and completing corrective action plans (CAPs) when applicable.
- Providing access to medical records for quality improvement projects and studies and HEDIS review
- Using preventive health and Clinical Practice Guidelines in member care
- Responding in a timely manner to requests for written information and documentation if a quality of care or grievance issue has been filed
- Sharing imperative data files, such as EMR and lab files
- Using the immunization registry
- Participating in performance improvement activities

Information from these studies is actively shared with providers and we encourage constructive feedback.

Community Advisory Committee

Community Advisory Committees (CAC) provide input and recommendations to the Board of Directors, Medical Advisory Committee and Quality department on programs and issues. These advisory functions include providing input on topics such as priorities for needs assessment, program development and provider network development.

The CAC (Community Advisory Committee) meets periodically in our California counties with representatives from Quality Management, Provider Relations, Community Based Organizations and Anthem members enrolled in Medi-Cal in attendance.

The responsibilities of the CAC are to:

- Give input to Anthem on the needs of the community.
- Provide suggestions on possible approaches and strategies to address issues raised by our members.
- Review and comment on group needs assessment results.
- Identify community resources to enhance the services offered to Anthem members.
- Be included and involved in policy decisions related to quality improvement, educational, operational and cultural competency issues affecting groups who speak a primary language other than English.

Provider Performance Data

Practitioners and providers must allow Medi-Cal to use performance data in cooperation with our quality improvement program and activities.

Provider performance data refers to compliance rates, reports and other information related to the appropriateness, cost, efficiency and/or quality of care delivered by an individual healthcare practitioner such as a physician or a healthcare organization such as a hospital. Common examples of performance data would include the HEDIS quality of care measures maintained by the NCQA, and the comprehensive set of measures maintained by the National Quality Forum (NQF).

Practitioner/provider performance data may be used for multiple plan programs and initiatives including, but not limited to:

- **Reward programs:** Pay for performance (P4P), pay for value (PFV) and other results-based reimbursement programs that tie provider or facility reimbursement to performance against a defined set of compliance metrics. Reimbursement models include but are not limited to shared savings programs, enhanced fee schedules and bundled payment arrangements.
- **Recognition programs:** Programs designed to transparently identify high-value providers and facilities and make that information available to consumers, employers, peer practitioners and other healthcare stakeholders.

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a national evaluation and core set of performance measurements that gauge the effectiveness of Anthem and its providers in providing quality care. Anthem will provide the necessary education and training you and your office staff need 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 QM staff will contact your office when we need to review or copy any medical records required for HEDIS or QM studies. Requests to provider offices begin in early February. Anthem requests the records be returned within five business days to allow time to abstract the records and request additional information from other providers if needed. Office staff must provide access to medical records for review and copying free of charge.

Over/Under Utilization

In accordance with NCQA standards, Anthem analyzes relevant utilization data against established thresholds for each health plan to detect potential over or under utilization.

If our findings fall outside specified target ranges and indicate potential underutilization or overutilization that may adversely affect our members, further analyses will occur based upon the recommendation of the Anthem Clinical Solutions Committee (CSC).

The follow-up analyses may include gathering the following data from specific provider and practice sites:

- Care 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 grievances and appeals within established time frames
- Retrospective reviews of services provided without authorization

Gaps in Care

The QM Department regularly tracks member utilization for nationally recognized standards of care. When members are due for care or gaps in care are identified, outreach staff engages with members directly and conducts outreach calls to the members, during which staff:

- Educate members on the importance of receiving their care.
- Identify barriers to care (for example, transportation) and work with members to overcome those barriers.
- Assist members with the scheduling of appointments.

The main healthcare service delivery areas targeted during member outreach include:

- Prenatal and postpartum care
- Chronic disease management (for example, diabetes, asthma, hypertension
- Childhood immunizations and well-child visits
- Routine preventive screenings (for example, breast cancer screening and pap smears)

Health topics may be targeted if significant gaps in care are identified by the QM team. The Care Delivery Team is available to support the network in closing gaps in care.

Member Satisfaction Surveys

Member satisfaction with our healthcare services is measured every year by the **Consumer Assessment of Healthcare Providers and Systems** (CAHPS®) survey. The survey is an NCQA requirement and is designed to measure member satisfaction with services provided by Anthem and our network providers including:

- Physician care and communication with patients
- Access to care
- Anthem Customer Service

Anthem shares results of the CAHPS survey with our network providers upon request. Providers can review the results, share them with office staff, and incorporate appropriate changes to their offices in an effort to improve scores on Provider Satisfaction Surveys.

Anthem conducts 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.

Facility Site and Medical Records Reviews

As required by California statute, all PCP sites participating in the Medi-Cal program must undergo an initial and subsequent site review regardless of the status of other accreditation or certification. The review consists of a facility site review and medical record review (FSR/MRR).

Anthem conducts subsequent period reviews at least every three years in order to determine:

- Provider compliance with standards for providing and documenting healthcare.
- Provider compliance with standards for documenting and storing medical records.
- Provider compliance with access standards and processes that maintain safety standards and practices.

Provider involvement in the continuity and coordination of member care.

Note: DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), Department of Managed Health Care (DMHC), or their designees and Anthem have the right to enter into 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 not to unduly delay work in accordance with the provider contract.

FSR and MRR tools and other resources are available under *Facility Site Review* heading on the Provider Resources Overview page of our website at providers.anthem.com/california-provider/resources/fsr.

Facility Site Review Process

An FSR inspection is broken down into the following six categories:

- Access/safety
- Personnel
- Office management
- Clinical services
- Preventive services
- Infection control

Critical elements include:

- Exit doors and aisles are unobstructed and escape accessible
- Airway management equipment is available
- Emergency medicine and supplies are available
- Only qualified/trained personnel retrieve, prepare or administer medications.
- Physicians review and follow-up referral/consultation reports and diagnostic test results
- Only lawfully authorized persons dispense drugs to patients
- Drugs and vaccines are prepared and drawn only prior to administration.
- Personal protective equipment for standard precautions is readily available for staff use.
- Needles stick safety precautions are practiced on site
- Blood, other potentially infectious materials, and regulated wastes are cared for and disposed of appropriately
- Spore testing of autoclaves completed at least monthly.
- Cold chemical sterilization/high level disinfection: Staff demonstrate/verbalize necessary steps/process to ensure sterility and/or high level disinfection of reusable instruments
- Cold chemical sterilization/high level disinfection: PPE, exposure control plan, MSDS and clean up instructions are available in the event of a cold chemical sterilant spill

Facilities must demonstrate 100 percent compliance with these elements.

The initial and subsequent reviews also consist of a Physical Accessibility Survey (PARS) to assess the physical adequacy of and access to provider sites that provide services to seniors and persons with disabilities.

The Anthem Quality Management team will call the provider's office to schedule an appointment date and time before the FSR due date. The team will fax, email, or mail a confirmation letter with an explanation of the audit process and required documentation.

During the FSR, our auditor will:

- Conduct a review of the facility and medical records
- Develop a Corrective Action Plan (CAP) if applicable.

After the FSR is completed, our auditor will meet with the provider or office manager to:

- Review and discuss the results of the FSR and MRR (Medical Record Requests) and explain any required corrective actions.
- Provide a copy of the review results and the required CAP, if any to the office manager or provider.
- Educate the provider and office staff about our standards and policies.
- Schedule a follow-up review for any corrective actions identified.

Providers must obtain a score of 80% or greater in both FSR and MRR in order to pass.

Provider sites that score below 80% in the facility site review for two consecutive reviews must score a minimum of 80% in the next review. Sites that do not score a minimum of 80% on their third consecutive attempt will be removed from the network, and the provider's members will be appropriately reassigned to other participating providers. This includes reviews conducted by other Managed Care Plans.

New provider sites requesting to join the network or established primary care providers relocating to or acquiring a new suite/address must achieve a passing score of 80% in their initial FSR and complete and close their CAP, if any, in order to be added to the network and have members assigned at the new location.

Facility Site Review: Corrective Actions

If the FSR and/or MRR results in a non-passing or conditional score, Anthem will immediately notify providers of the results as well as all cited deficiencies and corrective action requirements. The provider office will develop and submit a CAP as follows:

- Develop and submit a CAP and evidence of compliance/corrections for critical element (CE) deficiencies within 10 business days following the FSR
- Develop and submit a CAP and evidence of compliance/corrections for all other deficiencies within 30 calendar days from the date of written CAP request
- Sign an attestation when corrective actions are complete

If the CAP and evidence of compliance/corrections are not submitted by the above time frames, providers are otherwise uncooperative with resolving outstanding issues with the FSR/MRR, are considered noncompliant and will be subject to administrative actions which may include a temporary hold on new membership assignment or providers' removal from Anthem's primary care provider network. This includes reviews conducted by other Managed Care Plans.

Medical Records Review Process

Medical Records

Medical records must be maintained in a manner that ensures effective and confidential member care and quality review. At Anthem, we perform medical record reviews upon signing a provider contract and, at minimum, every three years thereafter to ensure providers are compliant these standards. Please see the Medical Record Review Process section for more information.

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 if in compliance with law. Providers must be familiar with the security requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and in compliance.

In addition, providers must provide access to medical records for the following:

- Medical record reviews by Anthem or the provider's contracted External Quality Review Organization (EQRO). Providers must have procedures in place to provide timely access to medical records in the providers' absence.

The Anthem QM team will call the provider's office to schedule a medical records review on a mutually agreed date and time. On the day of the review, the QM staff will:

- Request and review the number and type of medical records required per provider.
- Complete the medical record review.
- Meet with the provider or office manager to review and discuss the results of the medical record review
- Schedule follow-up reviews for any corrective actions identified.

Providers must attain an overall score of 80 percent or greater in order to pass the medical record review. A CAP will be required if the overall score is under 90 percent or any subsection score is under 80 percent to improve future documentation.

Provider sites that score below 80 percent in the medical record review for two consecutive reviews must score a minimum of 80% in the next review. Sites that do not score a minimum of 80 percent on their third consecutive review will be removed from the network, and the provider's members will be appropriately reassigned to other participating providers. This includes reviews conducted by other Managed Care Plans.

Anthem requires providers to maintain medical records in a manner that is current, organized and permits effective and confidential member care and quality review. Anthem performs medical record reviews of all PCPs and OB/GYNs (acting as PCPs) upon signing of a contract and, at a minimum, every three years thereafter to ensure that network providers are in compliance with these standards.

Confidentiality

Network providers shall agree to maintain the confidentiality of member information and information contained in a member's medical records according to the Health Information Privacy and Accountability Act (HIPAA) standards. The Act prohibits a provider of healthcare 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 and will only release such information as permitted by applicable federal, state, and local laws and that is:

- Necessary to other providers and the health plan related to treatment, payment or healthcare operations
- Upon the member's signed and written consent

Security

The medical record must be secure and inaccessible to unauthorized access in order to prevent loss, tampering, disclosure of information, alteration or destruction of the record. Information must be accessible only to authorized personnel within the provider's office, Anthem, DHCS or to persons authorized through a legal instrument.

Office personnel will ensure that individual patient conditions or information is not discussed in front of other patients or visitors, displayed, or left unattended in reception and/or patient flow areas.

Storage and Maintenance

Active medical records shall be secured and must be inaccessible to unauthorized persons. Medical records are to be maintained in a manner that is current, detailed and organized, and that permits effective patient care and quality review while maintaining confidentiality. Inactive records are to remain accessible for a period of time that meets state and federal guidelines (at least 10 years for pediatric and adult members).

Electronic recordkeeping system procedures shall be in place to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures and maintain upkeep of computer systems.

Security systems shall be in place to provide back-up storage and file recovery, to provide a mechanism to copy documents, and to ensure that recorded input is unalterable.

Availability of Medical Records

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

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

Medical records must be legible, signed and dated.

Providers must offer a copy of a member's medical record upon reasonable request by the member at no charge, and the provider must facilitate the transfer of the member's medical record to another provider at the member's request.

Confidentiality of and access to medical records must be provided in accordance with the standards mandated in HIPAA and all other state and federal requirements.

Providers must permit Anthem and representatives of DHCS to review members' medical records for the purposes of:

- Monitoring the provider's compliance with medical record standards
- Capturing information for clinical studies or HEDIS
- Monitoring quality
- Any other reason

Misrouted Protected Health Information

Providers and facilities are required to review all member information received from Anthem to ensure no misrouted protected health information (PHI) is included. Misrouted PHI includes information about members that a provider or facility is not treating. PHI can be misrouted to providers and facilities by mail, fax, email, or electronic remittance advice. Providers and facilities are required to destroy immediately any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or re-disclose misrouted PHI.

If providers or facilities cannot destroy or safeguard misrouted PHI, contact the appropriate Customer Care Center in Chapter 2: Quick Reference.

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, when there are preventable adverse events, they should be tracked and reduced with the ultimate goal of eliminating them.

Providers and healthcare systems, as advocates for our members, are responsible for the continuous monitoring, implementation, and enforcement of applicable healthcare standards. We strive and reinforce efforts to build a safer, equitable high-quality healthcare system and decrease the occurrence of patient safety events, provider preventable conditions (PPCs) and hospital-acquired and healthcare-acquired conditions (both referred to as HCACs). We advocate for a safety culture that improves the delivery of healthcare, health outcomes, and alignment with national patient safety efforts. In doing so, we are committed to working collaboratively with network providers and hospitals to promote safe practices and to identify and implement appropriate strategies, processes, and technologies to address and avoid PPCs and HCACs, including as it applies to health disparities. Our goal is to enhance the quality of care received not only by our members but all patients receiving care within individual practices and across the healthcare continuum.

Prevention of adverse events may require the disclosure of PHI. HIPAA specifies that PHI **can** be disclosed for the purpose of healthcare operations in relation to quality assessment and improvement activities. Moreover, the information you share with us is legally protected through the peer-review process. As such, it will be maintained in a strictly confidential manner. If you receive a request for medical records, please provide them within 10 days from the date of request.

We will continue to monitor activities related to the list of adverse events from federal, state, and private payers including **never events**.

Provider preventable conditions and HCACs should not occur. When they do, we firmly support the concept that a health plan and its members should not pay for resultant services, remaining consistent with CMS payment policy and as stated in Anthem's health reimbursement policy/contracts.

In the event that Anthem determines that the quality of care or services provided by a healthcare professional is not satisfactory, as may be evidenced by member satisfaction surveys, member complaints or grievances, medical management data, complaints or lawsuits alleging professional negligence, or any other quality of care indicator, Anthem may exercise any appropriate rights to terminate the Provider Agreement.

Note: Medicaid is prohibited from paying for certain Healthcare Acquired Conditions (HCAC). This applies to all hospitals.

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.

Chapter 14: Claims & Encounters

Reimbursement Policies

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Anthem covered the service for the member's benefit plan. These policies can be accessed on our website at providers.anthem.com/california-provider/claims/reimbursement-policies/medicaid-mmp.

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

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. The codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional 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.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Anthem strives to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Reimbursement Hierarchy

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

Schedules and Updates to Reimbursement Policies

Reimbursement policies undergo reviews for updates to state, federal, or CMS contracts and/or requirements.

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

Provider bulletins contain important information including, but not limited to, Fee Schedule update notices and can be accessed on our website at providers.anthem.com/california-provider/communications/news-and-announcements.

Reimbursement by Code Definition

Anthem allows reimbursement for covered services based on their procedure code definition, or descriptor, as opposed to their appearance under particular CPT categories or sections unless otherwise noted by state, federal or CMS contracts and/or requirements. There are seven 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. Our vendor-partner or our internal team may review these claims as part of our itemized bill review (IBR) program to ensure appropriate reimbursement. Upon completion of the review, documentation, including a summary of adjusted charges, will be provided for each claim. Disputes related to the review may be submitted according to the instructions in the Claims Payment Disputes section of this manual.

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

Audits/Records Requests

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

Blood, Blood Products and Administration

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

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

Emergency Room Supplies and Services Charges

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

Facility Personnel Charges

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

Implants

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

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

Iv Sedation and Local Anesthesia

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

Lab Charges

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

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

Labor Care Charges

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

Nursing Procedures

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

Operating Room Time and Procedure Charges

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

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

Personal Care Items and Services

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

Pharmacy Charges

Pharmacy charges will be reimbursed to include only the cost of the drugs prescribed by the attending physician. Medications furnished to patients shall not include an additional separate charge for administration of drugs, the cost of materials necessary for the preparation and administration of drugs, and the services rendered by registered pharmacists and other pharmacy personnel. All other services

are included in the drug reimbursement rate. Example of pharmacy charges which are not separately reimbursable include, but are not limited to: IV mixture fees, IV diluents such as saline and sterile water, IV Piggyback (IVPB), Heparin and saline flushes to administer IV drugs, and facility staff checking the pharmacy ("Rx") cart.

Portable Charges

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

Pre-Operative Care Or Holding Room Charges

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

Preparation (Set-Up) Charges

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

Recovery Room Charges

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

Recovery Room Services Related to IV Sedation and/or Local Anesthesia

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

Respiratory Services

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

Routine Supplies

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

Special Procedure Room Charge

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

Stand-by Charges

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

Stat Charges

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

Supplies and Equipment

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

Tech Support Charges

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

Telemetry

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

Time Calculation

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

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

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

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

Undocumented or Unsupported Charges

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

Video or Digital Equipment Used in Operating Room

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

Additional Reimbursement Guidelines for Disallowed Charges

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

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

Examples of non-reimbursable items/services codes (including but not limited to):	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed	**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

Examples of non-reimbursable items/services codes (including but not limited to):	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed	Description of Excluded Items
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) Stand-by Charges
0220, 0949	Stat Charges
0270 – 0279, 0360	Video Equipment Used in Procedures
0270, 0271, 0272	**Supplies and Equipment** Blood Pressure cuffs/Stethoscopes Thermometers, Temperature Probes 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) Bedpans/Urinals Bed Scales/Alarms Specialty Beds Foley/Straight Catheters, Urometers/Leg Bags/Tubing Specimen traps/containers/kits Tourniquets Syringes/Needles/Lancets/Butterflies Isolation carts/supplies Dressing Change Trays/Packs/Kits Dressings/Gauze/Sponges Kerlix/Tegaderm/OpSite/Telfa Skin cleansers/preps Cotton Balls; Band-Aids, Tape, Q-Tips Diapers/Chucks/Pads/Briefs Irrigation Solutions ID/Allergy bracelets Foley stat lock Gloves/Gowns/Drapes/Covers/Blankets Ice Packs/Heating Pads/Water Bottles Kits/Packs (Gowns, Towels and Drapes) Basins/basin sets Positioning Aides/Wedges/Pillows Suction Canisters/Tubing/Tips/Catheters/Liners Enteral/Parenteral Feeding Supplies (tubing, bags, sets) 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 and staple removers, sutures, scalpels, blades) IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags,

Examples of non-reimbursable items/services codes (including but not limited to):	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed	**Description of Excluded Items**
	adapters, caps, plugs, fluid warmers, sets, transducers, heparin and saline flushes)
0220 – 0222, 0229, 0250	**Tech Support Charges** Pharmacy Administrative Fee (including mixing meds) Portable Fee (cannot charge portable fee unless equipment is brought in from another facility) Patient transport fees
0223	Utilization Review Service Charges
0263	IV Infusion for therapy, prophylaxis (96365, 96366) IV Infusion additional for therapy IV Infusion concurrent for therapy (96368) IV Injection (96374, 96379)
0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310	Nursing Procedures and 99001 – Handling and/or conveyance of specimen from patient (charge for specimen handling)
0230	Incremental Nursing – General
0231	Nursing Charge – Nursery
0232	Nursing Charge – Obstetrics (OB)
0233	Nursing Charge – Intensive Care Unit (ICU)
0234	Nursing Charge – Cardiac Care Unit (CCU)
0235	Nursing Charge – Hospice
0239	Nursing Charge – Emergency Room (ER) or Post Anesthesia Care Unit (PACU) or Operating Room (OR)
0250 – 0259, 0636	**Pharmacy** Medication prep Nonspecific descriptions Anesthesia Gases – Billed in conjunction with Anesthesia Time Charges IV Solutions 250 cc or less, except for pediatric claims Miscellaneous Descriptions Compounding Fees
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	Venipuncture Specimen collection Draw fees Venipuncture Phlebotomy Heel stick Blood storage and processing blood administration Thawing/Pooling Fees

Examples of non-reimbursable items/services codes (including but not limited to):	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed	**Description of Excluded Items**
0270, 0272, 0300 – 0309	Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time)
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0410, 0460	**Supplies and Equipment** Oxygen Instrument Trays and/or Surgical Packs Drills/Saws (All power equipment used in O.R.) Drill Bits Blades IV pumps and PCA (Patient Controlled Analgesia) pumps Isolation supplies Daily Floor Supply Charges X-ray Aprons/Shields Blood Pressure Monitor Beds/Mattress Patient Lifts/Slings Restraints Transfer Belt Bair Hugger Machine/Blankets SCD Pumps Heel/Elbow Protector Burrs Cardiac Monitor EKG Electrodes Vent Circuit Suction Supplies for Vent Patient Electrocautery Grounding Pad Bovie Tips/Electrodes Anesthesia Supplies Case Carts C-Arm/Fluoroscopic Charge Wound Vacuum Pump Bovie/Electro Cautery Unit Wall Suction Retractors Single Instruments Oximeter Monitor CPM Machines Lasers Da Vinci Machine/Robot
0370 – 0379, 0410, 0460, 0480 – 0489	**Anesthesia (Specifically, conscious/moderate sedation by same physician or procedure nurse)** Nursing care Monitoring Intervention Pre- or Post-evaluation and education IV sedation and local anesthesia if provided by same physician or procedure nurse

Examples of non-reimbursable items/services codes (including but not limited to):	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed	Description of Excluded Items
	Intubation/Extubation CPR
0410	**Nursing Respiratory Functions** Oximetry Vent management Medication Administration via Nebs, Metered dose (MDI) Postural Drainage Suctioning Procedure
0940 – 0945	Education/Training

Claim Submissions

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 for timely filing. The provider or hospital shall bill Anthem within 180 days from the date of discharge for inpatient claims and 180 days from the date of service for outpatient and professional claims or Anthem may refuse payment.

Filing limits should be determined as follows:

- If Anthem is the primary payer, use the length of time between the last date of service on the claim and the Anthem receipt date.
- If Anthem is the secondary payer, use the length of time between the other payer's notice and **remittance advice** date and the Anthem receipt date.
- **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. To avoid missing deadlines, submit clean claims as soon as possible after delivery of service. In the event of an inconsistency between information contained in this Provider Manual and the Agreement between you and Anthem, the Agreement shall govern.
- Pursuant to the **California Welfare and Institutions Code (W&I) Section 14115**, DHCS allows for the following four exceptions to the 180-day filing limit:
  - If the patient has failed to identify himself or herself as a Medi-Cal beneficiary within four months after the month of service.
  - If a provider has submitted a bill to a liable third party, the provider has one year after the month of service to submit the bill for payment.
  - If a legal proceeding has commenced in which the provider is attempting to obtain payment from a third party, the provider has one year to submit the bill after the month in which the services have been rendered.
  - If Anthem finds that the delay in submission of the bill was caused by circumstances beyond the control of the provider.

Clean Claims

Use the following guidelines when submitting a claim:

- Submit clean claims, making sure that the correct and complete information is submitted on the correct form. A clean claim is a request for payment for a service rendered by a provider that:
  - Is submitted timely.
  - Is accurate.
  - Is submitted in a HIPAA-compliant format or using the standard claim form including a UB-04, CMS-1450 or CMS-1500 (02-12), or successor forms thereto, or the electronic equivalent of such claim form.
  - Requires no further information, adjustment, or alteration by the provider or by a third party in order to be processed and paid by us.
  - Submit claims as soon as possible after providing service.
  - Submit claims within the contract filing time limit.

In the event that Anthem does not reimburse a complete claim within 30 calendar days after receipt, interest will accrue at a rate of 15 percent per year beginning with the first calendar day after the 30-calendar-day period. Additionally, Anthem will continue to automatically include all accrued interest when making payment on a claim beyond the 30-calendar day requirement. Anthem will contest or deny a claim, or portion of a claim, as soon as practicable but no later than 30 calendar days after receipt of the claim.

Anthem will notify the claimant, in writing through Remittance Advice (RA) or a Claims Disposition Notice (CDN, that the claim is contested or denied, and shall identify the portion of the claim that is contested, by procedure or revenue code, and the specific information needed from the provider to reconsider the claim, including any defect or impropriety or additional information needed to adjudicate the claim.

For claims involving emergency services, the minimum amount of interest due is the greater of either $15.00 for each 12-month period or 15 percent per annum calculated as described above.

Paper claims that are determined to be unclean will be returned to the billing provider along with a letter stating the reason for the rejection. Electronic claims that are determined to be unclean will be rejected to the clearinghouse that submitted the claim. In the event you are a direct electronic submitter to Anthem, the claim will be returned to you directly.

Methods for Submission

There are two methods for submitting a claim:

- Electronically through Electronic Data Interchange (preferred)
- Paper or hard copy
  - CMS-1500 for Professional Services
  - UB-04 (CMS-1450) for facility and/or Outpatient Ancillary Services

Electronic Claims

If the service is the responsibility of Anthem, electronic filing methods are preferred for accuracy, convenience, and speed. Electronic submitters will receive electronic acknowledgement of the claim that has been submitted within 24 hours of receipt at Anthem.

Electronic Data Interchange

Availity is our exclusive partner for managing all Electronic Data Interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (835) allows for a faster, more efficient, and cost-effective way for providers to do business.

Use Availity for the following EDI transactions:

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

Availity's EDI submission options

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

EDI Response Reports

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

Availity EDI Payer IDs

Payer IDs ensure your EDI submissions are routed correctly when received by Availity.

Payer ID: 47198

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

Electronic Remittance Advice (ERA)

The 835 eliminates the need for paper remittance reconciliation. Use Availity to register and manage ERA account changes with these three easy steps:

1. Log in to Availity.com.
2. Select **My Providers**.
3. Select **Enrollment Center** and select **Transaction Enrollment**.

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

Electronic Funds Transfer (EFT)

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

Use EnrollSafe, enrollsafe.payeehub.org, to register and manage EFT account changes.

EDI Submission for Corrected Claims

For corrected electronic claims:

- Use frequency type (7) — Replacement of prior claim
- Submit original claim number for the corrected claim

EDI segments required:

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

Work with your vendor on how to submit corrected claims.

Paper Claims

If the service is the responsibility of Anthem and you are unable to submit the claim electronically, please mail paper claims to:

Claims and Billing
Anthem
P.O. Box 60007
Los Angeles, CA 90060-0007

If the service is the responsibility of one of our delegated entities, please send the claim to the responsible entity.

Paper claims must be legible and submitted in the proper format. Follow the guidelines below:

- Use the correct form and be sure the form meets CMA standards.
- Use black or blue ink (do not use red ink as the scanner may not be able to read it).
- 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.
- Separate each individual claim form. **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; leave a ¼-inch border on the left and right side of the form after removing perforated sides. This helps our scanning equipment scan accurately.
- Type information within the designated field. Be sure the type falls completely within the text space and is properly aligned.
- Handwritten claims need to use all capital letters and do not go outside of boxes into red areas. Use black ink and not markers.
- Do not highlight any fields on the claim forms or attachments; doing so makes it more difficult to create a clear electronic copy when scanned.
- If using a dot matrix printer, do not use draft mode since 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
- Rendering provider group or billing provider
- Federal provider tax identification number (TIN)
- National provider identifier (NPI)
- License number (if applicable)
- Medicare number (if applicable)

Note: Some claims may require additional attachments. Be sure to include all supporting documentation when submitting your claim.

A claim may be rejected or denied if it is submitted with incomplete or invalid information. It is the responsibility of the provider to submit accurate and timely information.

CMS-1500 Claim Form Fields

We encourage all providers to submit their professional claims to Anthem in an EDI format. In the event you need to submit a paper claim, please submit the most current version of the CMS-1500 claim form for professional services and UB-04 (CMS-1450) for facility and/or some ancillary charges. Before submitting the claim to Anthem, please verify if Anthem is responsible for payment of the service. The service may be delegated to a provider partner of Anthem.

#	Title	Explanation
1	Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA, Black Lung, Other	Indicate the type of health insurance coverage applicable to this claim by placing an X in the appropriate box. Only one box can be marked.
1a	Insured's ID Number	Enter the insured's ID number as shown on insured's ID card for the payer to which the claim is being submitted. If the patient has a unique member identification number assigned by the payer, enter that number in this field.
2	Patient's Name	Enter last name first, then first name and middle initial (if known). Do not use nicknames or full middle names. The ID card and the patient's name must be identical.
3	Patient's Birth Date	Enter the patient's 8-digit date of birth as MM/DD/CCYY.
4	Insured's Name	"Same" is acceptable if the insured is the patient. If the insurance is through a spouse or a parent, enter the insured's name.
5	Patient's Address/Telephone Number	Enter complete address. Include any unit or apartment number. Include abbreviations for road, street, avenue, boulevard, place. The NUCC recommends that the phone number not be reported. Phone extensions are not supported. Do not use punctuation in the address. Temporary addresses are not reported.
6	Patient Relationship to Insured	The relationship to the member such as self, spouse, children or other.
7	Insured's Address/Phone Number	"Same" is acceptable if the insured is the patient. It is not recommended to add the phone number as it is not transmitted over on the 837 file.
8	Reserved for NUCC Use	Leave blank for NUCC use.
9	Other Insured's Name	If there is other insurance coverage in addition to the member's coverage, enter the name of the insured. If the member has a Medigap policy different than that shown in item 2.
9a	Other Insured's Policy or Group Number	Enter the policy and/or group number of the secondary insurance (for example, Medigap insured preceded by MEDIGAP, MG or MGAP).
9b	Other Insured's Date of Birth	Enter date of birth in the MM/DD/YY format. If 9d is completed, leave blank.

#	Title	Explanation
9c	Employer's Name or School Name	Enter the claims processing address of the Medigap insurer If 9d is completed, leave blank.
9d	Insurance Plan Name or Program Name	Name of plan carrier.
10	Patient's Condition Related To	Include any description of injury or accident including whether it occurred at work.
10a	Related to Employment?	Y or N. If insurance is related to workers compensation, enter Y.
10b	Related to Auto Accident/Place?	Y or N. Enter the state where the accident occurred.
10c	Related to Other Accident?	Y or N.
10d	Reserved for Local Use	Condition codes: Approved for use in this item include codes for abortions, sterilization and codes for workman's compensation claims. When required by payers to provide the subset of condition codes approved by the NUCC, enter the condition code in this field. The condition codes approved for use on the 1500 claim form are available at nucc.org under *Code Sets*.
11	Insured's Policy Group of FECA Number, Date of Birth, Sex, Employer or School Name	Complete information about insured, even if same as patient. Medicare requires completion of these fields.
11a	Insured's Date of Birth	Enter the insured's 8-digit birth date (MM/DD/CCYY) and sex if different from item 3. If gender is unknown, leave blank.
11b	Other Claim ID designated by NUCC	When submitting to property and casualty payers (for example, automobile, homeowner's, or workers' compensation insurers and related entities), the following qualifier and accompanying identifier has been designated for use: Y4 Agency Claim Number (Property Casualty Claim Number). Enter the qualifier to the left of the vertical, dotted line. Enter the identifier number to the right of the vertical, dotted line.
11c	Insurance Plan Name or Program Name	Enter the name of the insurance plan or program of the insured.
11d	Is There Another Health Benefit Plan?	This is marked to indicate if the patient has secondary insurance. If item is marked "YES," items 9, 9a and 9d must also be completed.
12	Patient or Authorized Person's Signature	The patient's signature is required to authorize release of medical information to process the claim. Enter "Signature on File," "SOF," or legal signature. When legal signature, enter date signed in 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) format. If there is no signature on file, leave blank or enter "No Signature on File." Use the space available to enter signature/information and date.

#	Title	Explanation
13	Insured or Authorized Person's Signature	The patient's signature authorizes payment of medical benefits to the physician or supplier.
14	Date of Current Injury, Illness or Pregnancy	Enter an 8-digit (MM/DD/CCYY) or 6-digit (MM/DD/YY) date of current illness, injury or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. 431 Onset of Current Symptoms or Illness-484 Last Menstrual Period.
15	Other Date	Enter another date related to the patient's condition of treatment in either an 8-digit (MM/DD/CCYY) or 6-digit (MM/DD/YY) format. Enter the applicable qualifier to identify which date is being reported. Enter the applicable qualifier to identify which date is being reported.
16	Dates Patient Unable to Work in Current Occupation	If the patient is employed and unable to work in their current occupation, enter an 8-digit (MM/DD/CCYY) or 6-digit (MM/DD/YY) date when patient is unable to work. If the patient is treated for a work-related injury, the claim is submitted to worker's compensation and not the patient's medical insurance.
17	Name of Referring Provider or Other Source	Enter the other ID number of the referring, ordering or supervising provider.
17a	Other ID#	The other ID number of the referring, ordering or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a.The NUCC defines the following qualifiers used in 5010A1: • 0B State License Number • 1G Provider UPIN Number • G2 Provider Commercial Number • LU Location Number (This qualifier is used for supervising provider only.)
17b	National Provider Number	Enter the NPI of the referring/ordering/supervising physician or nonphysician practitioner listed in item 17b. NPIs are required.
18	Hospitalization Dates Related to Current Services	Enter the inpatient 6-digit (MM | DD | YY) or 8-digit (MM | DD | YYYY) hospital admission date followed by the discharge date (if discharge has occurred). If not discharged, leave discharge date blank. This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Additional Claim Information designated by NUCC	Payers have different uses for this field. "Additional claim information" identifies additional information about the patient's condition or the claim.
20	Outside Lab? $Charges	Complete this item when billing for purchased services by entering an "X" in "YES" (for example, diagnostic tests subject to the antimarkup payment limitation). This is not used in an ASC. When "YES" is marked, charges are entered to the left of the vertical line. Enter number right justified to the left of the vertical line. Enter "00" for cents if the amount is a whole number. Do not use dollar signs, commas or a decimal point when reporting amounts. Negative dollar amounts are not allowed. Leave the right-hand field blank.

#	Title	Explanation
21	Diagnosis or Nature of Illness or Injury	The "ICD Indicator" identifies the version of the ICD code set being reported. The "Diagnosis or Nature of Illness or Injury" is the sign, symptom, complaint or condition of the patient relating to the service(s) on the claim. Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 9 ICD-9-CM 0 ICD-10-CM
22	Resubmission and/or Original Reference Number	Enter the original reference number for resubmitted claims. When resubmitting a claim, enter the appropriate bill frequency. 7 = replacement of prior claim; 8 = void/cancel of prior claim.
23	Prior Authorization Number	The "Prior Authorization Number" is the payer assigned number authorizing the service(s). Enter any of the following: prior authorization number, referral number, mammography precertification number, or Clinical Laboratory Improvement Amendments (CLIA) number, as assigned by the payer for the current service.
24	Supplemental Information	Supplemental information can only be entered with a corresponding, completed service line. The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and another/proprietary identifier and to accommodate the submission of supplemental information to support the billed service. The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service. The supplemental information is to be placed in the shaded section of 24a through 24g as defined in each item number. Providers must verify requirements for this supplemental information with the payer.
24a	Date(s) of Service	"Date(s) of Service" indicates the actual month, day, and year the service(s) was provided. Grouping services refers to a charge for a series of identical services without listing each date of service.
24b	Place of Service	The "Place of Service" code identifies the location where the service was rendered. In 24b, enter the appropriate two-digit code from the Place of Service Code list for each item used or service performed. The Place of Service Codes are available at cms.gov/medicare/coding-billing/place-of-service-codes/code-sets.
24c	EMG	"EMG" identifies if the service was an emergency. Check with the payer to determine if this information (emergency indicator) is necessary. If required, enter Y for "YES" or leave blank if "NO" in the bottom, unshaded area of the field. The definition of emergency would be either defined by federal or state regulations or programs, payer contracts or as defined in 5010A1.
24d	Procedure, Services or Supplies	"Procedures, Services or Supplies" identify the medical services and procedures provided to the patient. Enter the CPT or HCPCS code(s) and modifier(s) (if applicable) from the appropriate code set in effect on the date of service. This field accommodates the entry of up to four two-digit modifiers. The specific procedure code(s) must be shown without a narrative description.

#	Title	Explanation
24e	Diagnosis Pointer	The "Diagnosis Pointer" is the line letter from item number 21 that relates to the reason the service(s) was performed. In 24e, enter the diagnosis code reference letter (pointer) as shown in item number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. ICD-10-CM diagnosis codes must be entered in item number 21 only. Do not enter them in 24e.
24f	$Charges	"$Charges" is the total billed amount for each service line. Enter the charge for each listed service.
24g	Days or Units	"Days or Units" is the number of days corresponding to the dates entered in 24a or units as defined in CPT or HCPCS coding manual(s). Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia units or minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered. For anesthesia services based on time, the number of minutes must be reported as t units.
24h	EPSDT Family Plan	For EPSDT-related services, enter the response in the shaded portion of the field as follows: Enter "Y" for EPSDT or "N" for non-EPSDT. The following codes for EPSDT are used in 5010A1: • AV Available – Not Used (Patient refused referral.) • S2 Under Treatment (Patient is currently under treatment for referred diagnostic or corrective health problem.) • ST New Service Requested (Referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals.) • NU Not Used (Used when no EPSDT patient referral was given.)
24i	ID Qualifier	Enter the shaded area of 24i the qualifier identifying if the number is a non NPI. The other ID # of the rendering provider should be reported in 24j in the shaded area. If the provider does not have an NPI number, enter the appropriate qualifier and identifying number in the shaded area. There will always be providers who do not have an NPI and will need to report non-NPI identifiers on their claim forms. The qualifiers will indicate the non-NPI number being reported. The NUCC defines the following qualifiers used in 5010A1: • 0B State License Number • 1G Provider UPIN Number • G2 Provider Commercial Number • LU Location Number • ZZ Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 claim form.)
24j	Rendering Provider ID#	The individual rendering the service should be reported in 24j. Enter the non NPI ID number in the shaded area of the field. Enter the NPI number in the unshaded area of the field. The individual performing/rendering the service should be reported in 24j and the qualifier indicating if the number is a non-NPI is reported in 24i. The non-NPI ID number of the rendering provider refers to the payer assigned unique identifier of the professional.

#	Title	Explanation
25	Federal Tax ID Number	Enter the "Federal Tax ID Number" (employer ID number or SSN) of the billing provider identified in item number 33. This is the tax ID number intended to be used for 1099 reporting purposes. Enter an "X" in the appropriate box to indicate which number is being reported. Only one box can be marked.
26	Patient's Account No	Enter the patient's account number assigned by the provider, service, or supplier's accounting system. This item is optional to assist the provider in patient identification.
27	Accept Assignment?	Check the appropriate block to indicate whether the provider of service or supplier accepts assignment. Accepting assignment means the provider agrees to the allowed amount (negotiated rate) for the charge.
28	Total Charge	Enter total charges for the services (for example, total of all charges in 24f). Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.
29	Amount Paid	The "Amount Paid" is the payment received from the patient or other payers. Enter the total amount the patient and/or other payers paid on the covered services only.
30	Reserved for NUCC Use	This field is reserved for NUCC use. The NUCC will provide instructions for any use of this field. Leave blank.
31	Signature of Physician or Supplier Including Degrees or Credentials	The "Signature of the Physician or Supplier Including Degrees or Credentials" refers to the authorized or accountable person and the degree, credentials, or title. Enter the signature if provider of service or supplier, or their representative, and either an 8-digit (MM/DD/CCYY) or 6-digit (MM/DD/YY) date, or alpha-numeric date the form was signed. This can be completed as "Signature on File" or "SOF" or a computer-generated signature.
32	Service Facility Location Information	Enter the name, address, city, state and ZIP code of the location where the services were rendered. Providers of service (namely physicians) must identify the supplier's name, address, ZIP code and NPI number when billing for purchased diagnostic tests. When more than one supplier is used, a separate 1500 claim form should be used to bill each supplier.
32a	NPI#	Enter the NPI number of the service facility location in 32a.Only report a service facility location NPI when the NPI is different from the billing provider NPI.
32b	Other ID#	The non-NPI ID number of the service facility is the payer assigned unique identifier of the facility. Enter the 2-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen or other separator between the qualifier and number. The NUCC defines the following qualifiers used in 5010A1: • 0B State License Number • G2 Provider Commercial Number • LU Location Number

#	Title	Explanation
33	Billing Provider Info & Ph #	Enter the provider's or supplier's billing name, address, ZIP code and phone number. The phone number is to be entered in the area to the right of the field title. Enter the name and address information in the following format: • 1st Line – Name • 2nd Line – Address • 3rd Line – City, State and ZIP Code • Item 33 identifies the provider that is requesting to be paid for the services rendered and should always be completed.
33a	NPI of Billing Provider	The NPI number refers to the HIPAA national provider identifier number. Enter the NPI number of the billing provider in 33a.
33b	Other ID#	The non-NPI ID number of the billing provider refers to the payer assigned unique identifier of the professional. Enter the 2-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen or other separator between the qualifier and number. The NUCC defines the following qualifiers used in 5010A1: • 0B State License Number • G2 Provider Commercial Number • ZZ Provider Taxonomy (The qualifier in the 5010A1 for provider taxonomy is PXC, but ZZ will remain the qualifier for the 1500 claim form.)

UB-04/CMS-1450 Claim Form Fields

We encourage all providers to submit their professional claims to Anthem in an EDI format. In the event you need to submit a paper claim, please submit the most current version of the CMS-1500 claim form for professional services and UB-04 (CMS-1450) for facility and/or ancillary charges. Before submitting the claim to Anthem, please verify if Anthem is responsible for payment of the service. The service may be delegated to a provider partner of Anthem.

#	Title	Explanation
1	Billing Provider Name, Address and Telephone Number	The name and service location provider submitting the bill. The billing provider address must be a street address. Use full nine-digit ZIP code XXXXX-XXXX.
2	Billing Provider's Designated Pay-to Address	The address that the provider submitting the bill intends payment to be sent is different than field 1. Address may include P.O. Box or street name and number, city, state, and ZIP. Use 5-digit ZIP code XXXXX.
3a	Patient Control Number	Patient's unique number assigned by the provider to facilitate retrieval of the individual's account of services containing the financial billing records and nay postings of payments.
3b	Medical/Health Record Number	The number assigned to the patient's medical/health record by the provider.
4	Type of Bill	A code indicating the specific type of bill (TOB) (for example, hospital inpatient, outpatient, replacements, voids). This is a four-digit code. First digit: leading zero/second digit: type of facility/third digit: bill classification/fourth digit: frequency of the bill.
5	Federal Tax Number	The number assigned to the provider by the federal government for tax reporting purposes, tax Identification number (TIN) or employer identification number (EIN).

#	Title	Explanation
6	Statement Covers Period (From-Through)	The beginning and ending service dates of the period are included on this bill. Format: MMDDYY.
7	Reserved for Assignment	Not used
8	Patient Name/Identifier	Last name, first name and middle initial of the patient and the patient identifier as assigned by the payer.
9	Patient Address	The mailing address of the patient. Enter the complete mailing address including street number and name or post office box number or RFD; city name; state; ZIP code.
10	Patient Birth Date	The date of birth of the patient. Format: MMDDYYYY
11	Patient Sex	The sex of the patient as recorded at admission, outpatient service or start of care. Format: M = male; F = female; U = unknown
12	Admission/Start of Care Date	The start date for this episode of care. For inpatient services, this is the date of admission. For other (home health) services, it is the date the episode of care began. Format: MMDDYYYY
13	Admission Hour	The code refers to the hour during which the patient was admitted for inpatient care. Enter the hour of admission to the 24-hour (00-23) format. Do not include the minutes.
14	Priority (Type) of Admission or Visit	A code indicating the priority of this admission/visit. **Code** **Type** **Code** **Type** 1 Emergency 4 Newborn-born outside hospital 2 Urgent 5 Trauma 3 Elective
15	Point of Origin for Admission or Visit	A code indicating the point of patient origin for this admission or visit. UB-04: Required on all bill types except 014x. **Code** **Type** **Code** **Type** 4 Transfer from a Hospital (Different Facility) E Transfer from Ambulatory Surgery Center (ASC) 5 Transfer from a Skilled Nursing Facility (SNF) F Transfer from a Hospice Facility 6 Transfer from another Healthcare Facility
16	Discharge Hour	The code refers to the hour during which the patient was admitted for inpatient care. Enter the hour of admission to the 24-hour (00-23) format. Do not include the minutes.
17	Patient Discharge Status	A code indicating the disposition or discharge status of the patient at the end of service for the period covered on this bill, as reported in FL6, Statement Covers Period.

#	Title	Explanation
18-28	Condition Codes	Condition codes are used to identify conditions related to the patient's bill that may affect payer processing. These codes should be entered from left to right in numeric-alpha sequence starting with the lowest value.
29	Accident State	The accident state field contains the two-digit state abbreviation where the accident occurred.
30	Reserved for Assignment by the NUBC	Not used.
31-34	Occurrence Codes and Dates	The code and associated date define a significant event relating to this bill that may affect payer processing. Occurrence codes and dates should be entered from left to right, top to bottom in numeric-alpha order starting with the lowest value.
35-36	Occurrence Span Codes and Dates	A code and the related dates that identify an event that relates to the payment of the claim. These codes identify occurrences that happened over a span of time. Enter all dates as month, day and year (MMDDYY).
37	Reserved for Assignment by the NUBC	Not used.
38	Responsible Party Name and Address (Claim Addressee)	The name and address of the party to whom the bill is being submitted. Address may include post office box or street name and number, city, state and ZIP code. Hospitals should abbreviate state in the address according to the post office standard abbreviations appearing in the instructions for Form Locator 01. The 9-digit ZIP code is used; it should be entered XXXXX-XXXX.
39-41	Value Codes and Amounts	A code structure to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization. Enter value codes and amounts from left to right, top to bottom in numeric-alpha sequence starting with the lowest value. Do not enter a decimal point (.), dollar sign ($), positive (+) or negative (-) sign. Enter full dollar amount and cents, even if the amount is even. Value codes and amounts are used to relate amounts to data elements necessary to process the claim. Value code information is required for Medicare/Medi-Cal crossover claims.
42	Revenue Codes (REV)	Codes that identify specific accommodation, ancillary service or unique billing calculations or arrangements.
43	Revenue Description/IDE Number/Medicaid Drug Rebate	The facility can use this form locator to enter a narrative description or standard abbreviation for each revenue code shown in FL 42 on the adjacent line in FL 43.
44	HCPCS/Accommodation Rates/HIPPS Rate Codes	1. The Healthcare Common Procedure Coding System (HCPCS) applicable to ancillary service and outpatient bills. 2. The accommodation rate for inpatient bills. 3. Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems.
45	Service Date	Enter the date the service was rendered in six-digit format MMDDYY.

#	Title	Explanation
46	Service Units	Enter the actual number of times a single procedure or item was provided for the date of service. If billing for more than 99, divide the units into two or more lines. Inpatient Claims: Enter the number of days of care by revenue code.
47	Total Charges	In full dollar amount, enter the usual and customary fee for the service billed. Do not enter a decimal point (.) or dollar sign ($). Enter full dollar amount and cents, even if the amount is even (for example, if billing for $100, enter “10000” not “100”).
48	Non-Covered Charges	The total noncovered charges pertaining to the related revenue code in FL 42 are entered here.
49		Not used.
50	Payer Name	Name of health plan that the provider might expect some payment for the bill.
51	Health Plan ID	The number is used to identify the payer or health plan.
52	Release of Information Certification Indicator	Code indicates whether the provider a signed statement (from the patient or the patient's legal representative) on file permitting the provider to release data to another organization.
53	Assignment of Benefits Certification Indicator	Code indicates provider has a signed form authorizing the third-party payer to remit payment directly to the provider.
54	Prior Payments - Payer	The amount the provider has received (to date) by the health plan toward payment of this bill.
55	Estimated Amount Due- Payer	The amount estimated by the provider to be due from the indicated payer (estimated responsibility less prior payments).
56	National Provider Identifier - Billing Provider	The unique identification number assigned to the provider submitting the bill; NPI is the national provider identifier.
57	Other (Billing) Provider Identifier	A unique identification number assigned to the provider submitting the bill by the health plan.
58	Insured's Name	The name of the individual under whose name the insurance benefit is carried.
59	Patient's Relationship to Insured	Code indicating the relationship of the patient to the identified insured.
60	Insured's Unique Identifier	The unique number assigned by the health plan to the insured.
61	Insured's Group Name	The group or plan name through which the insurance is provided to the insured.
62	Insured's Group Number	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.

#	Title	Explanation
63	Authorization Code/Referral Number	An identifier that designates services on this bill have been authorized by the payer or indicates that a referral is involved.
64	Document Control Number (DCN)	The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control.
65	Employer Name (of the Insured)	The name of the employer that provides healthcare coverage for the insured individual identified in FL 58.
66	Diagnosis and Procedure Code Qualifier (ICD Version Indicator)	The qualifier that denotes the revision of International Classification of Diseases (ICD) reported.
67	Principal Diagnosis Code and Present on Admission Indicator	The lCD diagnosis code, appropriate to the lCD revision indicated in FL 66 describes the principal diagnosis (in other words, the condition established after study to be chiefly responsible for occasioning the admission of the patient for care).
68		Not used.
69	Admitting Diagnosis Code	The ICD diagnosis code appropriate to the lCD revision indicated in field 66 describing the patient's diagnosis at the time of admission. The reporting of the decimal between the third and fourth character is unnecessary because it is implied. ICD-10 became effective 10/1/2015.
70a-c	Patient's Reason for Visit	The lCD diagnosis codes appropriate to the lCD revision indicated in field 66 describe the patient's stated reason for visit at the time of outpatient registration. The reporting of the decimal between the third and fourth character is unnecessary because it is implied. ICD-10 became effective 10/1/2015.
71	Prospective Payment System (PPS) Code	The PPS code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.
72a-c	External Cause of Injury (ECI) Code and Present on Admission Indicator Element	The lCD diagnosis codes appropriate to the lCD revision indicated in field 66 pertaining to the environmental events, circumstances and conditions as the cause of injury, poisoning and other adverse effects. The reporting of the decimal between the third and fourth character is unnecessary because it is implied. ICD-10 became effective 10/1/2015.
73		Not used.
74	Principal Procedure Code and Date	Enter the appropriate ICD-10-PCS code identifying the primary medical or surgical procedure. Enter the ICD-10-PCS code without periods or spaces between the numbers. In 6-digit format, enter the date the surgery or delivery was performed.
74a-e	Other Procedure Codes and Dates	Enter the appropriate ICD-10-PCS code identifying the secondary medical or surgical procedure without period or spaces between the numbers.
75		Not used.

#	Title	Explanation
76	Attending Provider Name and Identifiers	Inpatient claim: The attending provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim. Outpatient claim: Enter the referring or prescribing physician's NPI in the first box.
77	Operating Physician Name and Identifiers	Inpatient claim: The name and identification number (NPI) of the individual with the primary responsibility for performing the surgical procedure(s). Do not enter a group provider number. Outpatient claim: Enter the rendering physician's name and identification number (NPI) in the first box.
78-79	Other Provider (Individual) Names and Identifiers	The name and ID number of the individual corresponding to the Provider Type category indicated in this section of the claim. Inpatient claim: Enter the admitting physician's name and individual identification number (NPI).
80	Remarks Field	If additional information cannot be completely entered in this field, attach the additional information to the claim on single-sided 8½ by 11-inch white paper.
81	Code-Code Field	To report additional codes related to a field (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

Claims Processing: Document Control Number

All claims accepted by Anthem are assigned a unique document control number (DCN). The DCN identifies and tracks claims that are accepted by Anthem. This number contains the Julian date, which indicates the date the claim was received.

Document control numbers are composed of 11 digits:

- 2-digit plan year
- 3-digit Julian date
- 2-digit Anthem reel identification
- 4-digit sequential number

Claims Processing: McKesson ClaimsXten

For claims processing, Anthem uses claims editing software from McKesson called ClaimsXten. ClaimsXten incorporates McKesson editing rules that apply plan payment policies.

The rules determine whether a claim should be paid, rejected, or require manual processing.

The editing rules evaluate Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes on the CMS-1500 form. A claim auditing action then determines how the procedure codes and code combinations will be adjudicated. The auditing action recognizes historical claims related to current submissions and may result in adjustments to previously processed claims. Providers can refer to McKesson ClaimsXten™ rules by logging onto Availity Essentials at Availity.com.

ClaimsXten may be updated periodically. Anthem will notify providers with advance notice as per the Provider Agreement.

Newborns

Newborns of Medi-Cal members are covered under the mother using the mother's Client Index Number (CIN) for the month of birth and the following month or until such time as the California Department of Health Care Services issues a dedicated CIN for the newborn.

Electronic Visit Verification (EVV)

In accordance with federal and state laws, Anthem is implementing electronic visit verification (EVV) for all Medi-Cal providers that are delivered during in-home visits by the provider. Electronic Visit Verification (EVV) is a telephone and computer-based solution that electronically verifies when in-home service visits occur.

Providers rendering in-home service visits are required to be registered and trained in an approved EVV system. Anthem will use and encourage subcontractors and network providers to use the state-sponsored EVV system, Sandata Technologies, LLC (Sandata). Sandata's EVV system has the ability to capture data elements during the visit, data portals to allow providers to view and report on visit activity, and an EVV Aggregator to provide EVV program oversight and analytics. The EVV Aggregator also has the ability to receive data from providers that choose to use their existing EVV system. Anthem will not require additional expenditures or efforts by Members, should an alternate EVV system be used.

All Medi-Cal providers must capture and transmit the following six mandatory data components:

- Type of service performed.
- Individual receiving the service.
- Date of the service.
- Location of the service.
- Individual providing the service.
- Time the services begins and ends.

All network providers are required to comply with the EVV requirements subject to federal EVV requirements. Anthem will:

- Monitor provider compliance with EVV requirements and CalEVV Information Notice(s) and notify DHCS with any compliance issues
- Supply providers with technical assistance and training on EVV compliance
- Require providers to comply with an approved corrective action plan
- Deny payment if the Provider is not complying with EVV requirements and arrange for Members to receive services from a Provider who does comply

If a Network Provider is identified as non-compliant with EVV requirements, Anthem will not authorize the Network Provider to perform services and/or withhold payment.

Monitoring and Oversight

Anthem will monitor providers submitting claims for any service that requires an accompanying EVV visit for compliance with following:

- Being registered with Sandata or an Alternate EVV system
- Submitting claims with an EVV code, but did not include an accompanying EVV visit
- Submitting claims with an EVV code, but the accompanying EVV visit is missing any of the six mandatory data component.

Claims Coding and Documentation

Claims submitted with incomplete or invalid information will be rejected or denied and will need to be resubmitted when applicable. Whether you submit a claim electronically or on paper, the claim may be rejected/returned back to the submitter if it contains incomplete or invalid information and or is not deemed a clean claim.

National Drug Code Coding

Medi-Cal billings for pharmaceuticals dispensed in both professional and institutional settings should include the following information:

- National Drug Codes (NDCs)
- Healthcare Common Procedure Coding System (HCPCS) code
- Unit of measurement
- Unit quantity

When billing for members enrolled in Medi-Cal, providers are required to include a Universal Product Number (UPN), invoice submissions or for Enteral Medical Billing Number (MBN) for claims involving medical supplies.

Clinical Laboratory Improvement Amendments (CLIA) Requirements

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

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

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

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

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

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

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

International Classification of Diseases, 10th Revision Description

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

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

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

- Clinical modification (CM): ICD-10-CM is used for diagnosis coding
- Procedure coding system (PCS): ICD10PCS is used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States.

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

National Provider Identifier

The National Provider Identifier (NPI) is a 10-digit, all numeric identifiers. NPIs are only issued to providers of health services and supplies. As a provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the NPI is intended to improve efficiency and reduce fraud and abuse.

NPIs are divided into two types:

- **Type 1**: individual providers, which includes but is not limited to physicians, dentists, and chiropractors
- **Type 2**: hospitals and medical groups, which includes but is not limited to hospitals, residential treatment centers, laboratories, and group practices

For billing purposes, claims must be filed with the appropriate NPI for billing, rendering, and referring providers. Providers may apply for an NPI online at the National Plan and Provider Enumeration System (NPPES) website at nppes.cms.hhs.gov.

You may also get a paper application by calling NPPES at **800-465-3203**.

Clinical Submission Categories

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

- Claims involving precertification/prior authorization/pre-determination (or some other form of utilization review) including, but not limited to:
  - Claims pending for lack of precertification or prior authorization
  - Claims involving medical necessity or experimental/investigative determinations
  - Claims for Injectables requiring prior authorization
- Claims requiring certain modifiers including local code (HCPCS Level III Interim codes if required)
- Claims involving unlisted codes
- Claims for which we cannot determine from the face of the claim whether it involves a covered service; thus, benefit determination cannot be made without reviewing medical records including, but not limited to, preexisting condition issues, emergency service-prudent layperson reviews and specific benefit exclusions
- Claims that we have reason to believe involve inappropriate (including fraudulent) billing
- Claims that are the subject of an audit (internal or external) including high-dollar claims
- Claims for individuals involved in case management or disease management
- Claims that have been appealed (or that are otherwise the subject of a dispute including claims being mediated, arbitrated, or litigated)

Other situations in which clinical information might routinely be requested:

- Accreditation activities
- Coordination of benefits
- Credentialing
- Quality improvement/assurance efforts
- Recovery/subrogation

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

Billing Requirements for Professional, Institutional and Ancillary Claims

HIPAA compliant code sets must be used.*

HCPCS is an acronym for Healthcare Common Procedure Coding System. Standardized code sets are necessary for Medicare and other health insurance providers to provide healthcare claims that are managed consistently and in an orderly manner. HCPCS Level II coding system is one of several code sets used by healthcare professionals including medical coders and billers. The Level I HCPCS code set includes CPT codes. CPT is developed and owned by the American Medical Association (AMA).

CPT codes are the United States' standard for how medical professionals document and report medical, surgical, radiology, laboratory, anesthesiology, and evaluation and management (E/M) services. All healthcare providers, payers and facilities use CPT codes.

HIPAA-compliant codes fall into three categories:

1. **Category I** (CPT codes): These five-digit codes have descriptors which correspond to a procedure or service. Codes range from 00100-99499.
    - Modifier and/or revenue codes: Use modifier and revenue codes when appropriate with the corresponding HCPCS or CPT codes.
2. **Category II** (HCPCS): These alphanumeric tracking codes are used for execution measurement.
3. **Category III** (interim/temporary codes): These are provisional codes for new and developing technology, procedures, and services. The codes were created for data collection and assessment of new services and procedures.*

* In addition to the HIPAA-compliant codes, the California Department of Health Care Services (DHCS) created a separate set of codes and modifiers for its Medi-Cal program, sometimes called Category III — Interim (local codes). These codes and modifiers identify services and products specific to Medi-Cal. Mid-level practitioners: Indicate the name and license number in Box 19 of the CMS-1500 form; the supervising physician's license number should be entered in Box 24j. The following are defined as mid-level:

- Physician assistants
- Nurse practitioners
- Certified nurse midwives
- Licensed midwives

Prior Authorization Number: Indicate the prior authorization number in Box 23 of the CMS-1500 form. There are certain exceptions to the prior authorization requirement. Professional and facility claims for emergency services are not denied due to lack of prior authorization. Emergency services are determined by diagnosis codes and/or services billed.

Member ID Number: Use the member's **Client Index Number** (CIN) when billing, whether submitting electronically or on paper. It is important to use the member's plan ID card number, **not** the number on the identification card issued by the state.

On-Call Services: Insert **On-Call** for PCP in Box 23 of the CMS-1500 form when the rendering physician is not the PCP but is covering for or has received permission from the PCP to provide services that day.

Note: When a provider/facility's reimbursement is affected by a contract change during a course of treatment, the provider/facility is required to split the dates of service if you are a per-diem contracted provider/facility. This will allow your claim to be reimbursed at the appropriate rate.

Reporting Provider Preventable Conditions on Present on Admission Claims

Medi-Cal providers are required to report provider preventable conditions (PPCs) with POA claims. This reporting is required for claims for Medi-Cal payment or when treatment is given to a Medi-Cal member for which payment would be available.

Providers do not need to report PPCs that existed before the provider-initiated treatment for the Medi-Cal member. The new federal regulations prevent Anthem from paying providers for the treatment of PPCs. To ensure compliance, DHCS will investigate all reports of PPCs to determine if payment adjustment is necessary.

Note: Reporting PPCs for a Medi-Cal member does not prevent or exclude the reporting of adverse events to the California Department of Public Health pursuant to Health and Safety Code Section 1279.1.

Scope of POA and PPC Claims
The following is a list of preventable conditions where payment is prohibited:

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and trauma:
  - Fractures
  - Dislocations
  - Intracranial injuries
  - Crushing injuries
  - Burns
  - Electric shock
- Manifestations of poor glycemic control:
  - Diabetic ketoacidosis
  - Nonketotic hyperosmolar coma
  - Hypoglycemic coma
  - Secondary diabetes with ketoacidosis
  - Secondary diabetes with hyperosmolarity
- Catheter-associated urinary tract infection (UTI)
- Vascular catheter-associated infection
- Surgical site infection following:
  - Coronary artery bypass graft (CABG) — mediastinitis
  - Bariatric surgery
- Laparoscopic gastric bypass
- Gastroenterostomy
- Laparoscopic gastric restrictive surgery
- Orthopedic procedures:
  - Spine
  - Neck
  - Shoulder
  - Elbow
- Deep vein thrombosis (DVT)/pulmonary embolism (PE) (not included for Medicaid for pediatric and obstetric populations)
- Total knee replacement
- Hip replacement

Additionally, Anthem may not pay for the following events:

- Surgery on the wrong patient
- Wrong surgery on a patient
- Wrong site surgery

The below Table of Indicator Codes for PPC forms includes the codes to be used on the PPC form. Using the codes correctly ensures you are reimbursed as appropriate.

Indicator	Description	Reimbursable
Y	The condition was present on admission.	Yes
N	The condition was not present on admission.	No
W	The provider determined that it was not possible to document if the condition was present on admission.	Yes
U	The documentation was insufficient to determine if their condition was present on admission.	No

Claim Processing

Claims Returned for Additional Information

Anthem may send you a request for additional or corrected information when the claim cannot be processed due to incomplete, missing, or incorrect information. The request will indicate how long you have to return the information to Anthem.

Capitated Group Claims Processing

When claims processing is a delegated activity, Anthem oversees the processing and dispute resolution to ensure that both are conducted in a timely manner and in accordance with state/federal regulations and contractual agreements.

Groups must have written procedures for claims processing available for review.

These procedures are outlined in your Anthem State Sponsored Business Group Agreement. These procedures and disclosures must comply with state/federal laws and regulations and our contractual standards and requirements. They must also be made available upon request by Anthem or a regulatory agency.

Group claims processing systems must identify and track all claims activities including claims disputes and resolutions and be able to deliver monthly reports. Groups must be able to identify and acknowledge the receipt of each claim, whether or not complete, and disclose the recorded date of receipt in the same manner as the claim was submitted:

- If the claim was received electronically, the group must provide acknowledgement within two business days of receipt of the claim.
- If the claim was a paper claim, the group must provide acknowledgement within 15 business days of receipt of the claim.

Groups must pay a clean claim (or a portion thereof) or contest or deny a claim (or a portion thereof) within 45 business days of receipt of the claim (or within contractual time frames, which comply with the time frames set forth in this section). The group's request for additional information must be sent to the provider of service with a due date for the requested information:

- Payment of a clean claim or notification of a denial must be sent, accompanied by remittance advice (RA), to the provider of service within 45 business days of the date a claim is received.
- The date of payment or notification of denial is the postmarked date of the payment.
- The provider and member must be notified if a claim is denied, adjusted, or contested. The notification must include an understandable written explanation of the reasons for the denial, adjustment, or contested elements.

Groups must have a dispute resolution mechanism in place that allows providers to file a dispute within 365 days of receipt of an RA. All disputes must be resolved within 45 business days of the group's receipt of the dispute or as required by applicable state/federal law. Check out IPA contract language.

If a group determines that a claim was overpaid, the group must notify the provider in writing of the overpayment:

- The written notice must identify the claim, the name of the member, the date of service and a clear explanation of the basis upon which the group believes the amount paid was in excess of the amount due, including interest and penalties.
- Providers have 30 days from the receipt of the notice of the overpayment to contest or reimburse the overpayment.

The responsibility for claims payment as outlined above continues until all claims have been paid or denied for services rendered pursuant to your Anthem State Sponsored Business Group Agreement.

For questions related to delegation of claims processing activities, contact your group administrator.

Electronic Remittance Advice

Anthem offers secure electronic delivery of remittance advice, which explains claims in their final status. This service is offered through **Electronic Data Interchange** (EDI). For more information, providers and vendors may call the EDI Solutions Helpdesk:

- Availity Client Services: **800-282-4548**

Electronic Funds Transfer

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

Visit anthem.com/ca/provider/edi for EFT registration instructions.

Coordination of Benefits/Third Party Liability

Anthem may coordinate benefits with any other healthcare program that covers our members including Medicare. Indicate other coverage information on the appropriate claim form. If there is a need to coordinate benefits, include at least one of the following items from the other healthcare program when submitting a **Coordination of Benefits** (COB) claim:

- Third-party Remittance Advice (RA)
- Third-party provider Explanation of Benefits (EOB)
- Notice from third party explaining 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. Please make sure that the information you submit **explains all coding** listed on the other carrier's RA or letter. We cannot process the claim without this specific information.

The filing limits for COB claims are as follows:

- 180 days: for hospitals, institutions, and professional services providers
- 365 days: for ancillary service providers
- Claims follow-up resubmissions are subject to the 90-day resubmission filling limit

Claims Status

You can check the status of a claim anytime by logging in to Availity Essentials at Availity.com > Claims & **Payments** > **Claim Status**.

Note: The Interactive Voice Response (IVR) accepts either your National Provider Identifier (NPI) or your Federal Tax Identification Number (TIN) for provider ID. Should the system not accept those numbers, it will redirect your call to the Customer Care Center. For the purpose of assisting you, we may ask again for your TIN.

Claims Follow-Ups/Resubmissions

Providers can initiate a follow-up to determine claim status by going to the Availity Essentials platform. From the **Claims and Payments** menu there are options to view the status of the claim and submit a dispute, view the status of submitted disputes, submit a corrected claim electronically, or submit a medical record in support of a pended or denied claim.

When resubmitting a claim by paper, take the following steps:

1. Complete all required fields as originally submitted and mark the change(s) clearly.
2. Write or stamp "corrected claim" across the top of the form.
3. Attach a copy of the RA/EOB and state the reason for resubmission.
4. Attach all supporting documentation.
   - Mail to:
     Anthem
     P.O. Box 60007
     Los Angeles, CA 90060-0007

Misdirected Claims

In compliance with Section 1300.71 of Title 28 of the California code of Regulations (CCR), Claims Settlement Practice, Anthem policy states that any misdirected claims are redirected to the appropriate medical group or capitated hospital within ten (10) working days of receipt of the claim that was sent to Anthem.

If a claim is sent to Anthem but one of Anthem's capitated providers is responsible for adjudicating the claim, Anthem shall do the following:

a. For a provider claim involving emergency service and care, Anthem shall forward at least 95% of such claims to the appropriate delegated provider within ten (10) working days of receipt of the claim that was incorrectly sent to Anthem.
b. For a provider claim that does not involve emergency service or care:
    - If the provider that filed, the claim is contracted with one of Anthem's delegated providers; Anthem with at least 95% of the claims received; within (10) working days shall either:
        - Send the claimant a notice of denial, with instructions to bill the capitated provider OR
        - Forward the claim to the appropriate capitated provider.
    - In all other cases, Anthem, within ten (10) working days of the receipt of the claim incorrectly sent to Anthem shall forward the claim to the appropriate capitated provider.

If a claim is sent to one of Anthem's capitated provider and Anthem is responsible for adjudicating the claim, the capitated provider must redirect at least 95% of claims to Anthem within ten (10) working days of the receipt of the claim incorrectly sent to the plan's capitated provider.

Overpayment and Recovery

Providers are required to report to Anthem when they have received an overpayment, to return the overpayment within 60 calendar days after the date on which the overpayment was identified, and to notify in writing of the reason for the overpayment.

Anthem seeks recovery of all excess claim payments from the person or entity to whom the benefit check is 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 check along with a copy of the notification or other supporting documentation within 30 days to the following address:

Anthem
Overpayment Recovery
P.O. Box 73651
Cleveland, OH 44193-1177

If Anthem does not hear from you or receive payment within 30 days, the overpayment amount is deducted from future claims payments. In cases where Anthem determines that recovery is not feasible, the overpayment is referred to a collection service.

Encounters

Quality Measures for Encounter Data

Per APL 26-003, the California Department of Health Care Services (DHCS) implemented Quality Measures for Encounter Data 2.0 (QMED 2.0) program for managed care organizations in California. As a result, Anthem is continuing to implement quality standards for encounter submissions and medical records. These standards relate to:

- Data Uniqueness
- Data completeness
- Data accuracy
- Data reasonability
- Data timeliness

Note: These standards do not supersede the current claims timely filing requirements for fee-for-service claim submissions.

Data Completeness and Data Accuracy

Under the QMED program, the DHCS Audits and Investigations Division (A&I) will draw a random sample from the encounters submitted and request the corresponding medical records from the provider to check for data completeness. In addition, DHCS will randomly select a second medical record for the same beneficiary (if applicable) to verify if a corresponding encounter is in the DHCS data warehouse. This subsequent medical record will also be audited for data completeness.

In an encounter data validation study commissioned by DHCS, key data elements were evaluated for data completeness. The study found a lack of correlation between the medical records and corresponding encounter records. Providers are required to submit complete and accurate data elements, and Anthem will begin auditing medical records to assess data completeness and accuracy.

Data Completeness

Encounter data is complete when it includes the following:

- Correct billing provider name
- Correct date of service
- Complete beneficiary information

Data Accuracy

Accurate encounter data means:

- Correct rendering provider data
- Correct diagnosis codes(s)
- Correct procedure code(s)
- Correct procedure code modifier(s)
- Correct NDC match for J3490/J3590

Data Reasonability

Encounter data is reasonable when both the individual data and the data as a whole include valid dates and accurate information. To ensure the accuracy and acceptability of encounter data, providers must use valid national standard codes for procedure codes, revenue codes and diagnosis codes. Providers must ensure a valid National Provider Identifier (NPI) is used for billing provider, rendering provider, referring provider and prescribing provider.

Data Timeliness

The QMED program will also measure data timeliness, or the lag-time, in days, between the date of service (DOS) and the claims submission date. The DOS refers to the last date of service at the claim level or the first date of service if the last date of service is null. Providers are expected to submit encounter data no less than weekly to Anthem, whether a provider uses a clearinghouse or submits encounter data directly to Anthem. Do not delay, submit your encounter immediately following the service to ensure timely handling of the data.

Contracted providers are required to submit encounter data to Anthem according to the following guidelines:

- Group - Professional/Outpatient
  - 65% of Encounters within 60 days*
  - 70% of Encounters within 90 days*
- Facility – Inpatient/Outpatient
  - 60% of Encounters within 60 days*
  - 65% of Encounters within 90 days*

Completeness Threshold

The QMED program includes an Encounter Completeness threshold by county for each aid code (ACA optional expansion, Adult, Child, and SPD) as well as category of service (combined outpatient and ER, inpatient, pharmacy, and professional) for encounter submissions. These DHCS-required thresholds are based on data from annualized encounters per thousand members and are subject to change when DHCS revises each respective threshold. Providers are required to submit encounters in accordance with the thresholds. Anthem will notify providers as the thresholds are updated by DHCS.

If you have any questions, contact your regional health plan:

Health Plan	Detail
Fresno/Madera:	559-353-3500
Los Angeles	866-465-2272
Sacramento/Bay Area	916-589-3030
Tulare/Kings	559-623-0480

Third Party Tort Liability

Providers are required to submit service and utilization information and copies of paid invoices/claims for covered services related to third party liability torts to Anthem when requested.

DHCS has the right to recover funds related to services paid for by Medi-Cal for injuries a member sustains, for which a member receives a settlement, judgment, or award from a liable third party for

those same injuries. Accordingly, DHCS retains the right to impose liens in TPL torn actions or claims involving Medi-Cal members. Instances that may give rise to tort liability, but are not limited to, auto accidents, slip-and-falls, animal attacks, product or premises liability, medical malpractice, class actions, and workers' compensation claims.

Providers must submit service and utilization information and, when requested, copies of paid invoices/claims for covered services to Anthem within five days of Anthem's request. Service and utilization information and copies of paid invoices/claims for covered services must include any services provided, including but not limited to physical, mental, and dental health services. Records must include services provided on a fee-for-service, capitated, or other payment arrangement, regardless of whether payment was made or denied. This information must contain the following data elements:

- Name of the Managed Care Plan/Independent Physician Association (IPA)
- Member name
- Date of birth
- Client index number (CIN)
- Date of injury
- Claim control number
- Claim line number
- Claim type
- Service from date
- Service to date
- Provider legal name
- National provider identifier
- Diagnosis code 1 (primary diagnosis)
- Diagnosis code 2 (secondary diagnosis)
- Drug label name
- Amount billed
- Amount paid (the actual amount the MCP paid to the provider for services. If service is capitated, include amount as "0")
- Reasonable value
- Current procedural terminology (CPT)
- CPT type
- Primary/secondary claim deny reason code and description(s)

Alternative Payment Methodology (APM)

The California Department of Health Care Services (DHCS) has developed State's new Alternative Payment Model (APM) for participating Federally Qualified Health Centers (FQHCs) in a manner to incentivize delivery system and practice transformation through the flexibilities available under a fully capitated reimbursement model on a per member per month (PMPM) basis.

FQHCs participating in this APM would be able to move away from the volume based, per visit payment (FFS) to a front-loaded reimbursement (Capitation) methodology.

This is a voluntary program for qualified FQHC's who choose to participate.

Anthem engages in an alternative payment methodology (APM) program for those Federally Qualified Health Centers (FQHCs) deemed eligible by the Department of Health Care Services (DHCS).

This program provides a specified capitated payment for assigned members or a fee for service payment when members obtain care at a non-contracted APM-participating FQHC.

The APM program also provides for the sharing of specified data, quality monitoring, and dispute resolution.

Chapter 15: State Directed Payments

Proposition 56

In November 2016, voters passed Proposition 56 to support access to healthcare for low-income Californians covered by the Medi-Cal program. Known as the California Healthcare Research and Prevention Tobacco Tax Act, Proposition 56 raised the tax rate on cigarettes and other tobacco products to fund specific DHCS health care programs, including women's health services, dental and physician services, developmental and trauma screenings, non-emergency medical transportation, the Family Planning, Access, Care and Treatment program (Family PACT), and more.

Proposition 56 payments are made in accordance with the timely payment standards for clean claims or accepted encounters that are received by Anthem. Anthem is not required to make the supplemental payments described in this policy for clean claims or accepted encounters received by Anthem more than one (1) year after the date of service. These timing requirements may be waved through a written agreement between Anthem (or an Anthem subcontractor) and the affected provider.

The Proposition 56 Value-Based Payment (VBP) program under APL 23-014 has ended effective June 30, 2022.

The Proposition 56 Physician Services program defined under APL 23-019 ended effective December 31, 2023.

Program	All Plan Letter	Effective Date	End Date
Adverse Childhood Experiences (ACE)	APL 23-017	01/01/2020	
Developmental Screening Services	APL 23-016	01/01/2020	
Physician Services	APL 23-019	07/01/2017	12/31/2023
Private Services (HYDE)	APL 23-015	07/01/2017	
Family Planning	APL 23-008	07/01/2019	
Value-Based Payment (VBP)	APL 23-014	07/01/2019	06/30/2022

Qualifying services under Adverse Childhood Experiences (APL 23-017), Developmental Screening (APL 23-016), and Private Services (APL 23-019) must be billed directly to Anthem for reimbursement at the minimum fee schedule rate and are not the responsibility of subcontractors (PMG/IPA) to pay.

For questions regarding proposition 56 payments providers can contact Anthem at prop56@anthem.com.

Anthem has a formal procedure for the acceptance, acknowledgment, and resolution of Provider grievances related to the processing or non-payment of a directed payment. The provider claims dispute process is communicated in the claim payment dispute subsection of this manual.

Chapter 16: Targeted Rate Increase (TRI)

For dates of service on or after January 1, 2024, Anthem must reimburse each qualifying service provided by an eligible Network Provider at the TRI Fee Schedule rate pursuant to APL 25-012.

Eligible network providers are defined by APL 25-012 as participating providers under APL 19-001 and rendering services under one of the following specialty classifications:

- Physicians
- Physician assistants
- Nurse practitioners
- Podiatrists
- Certified nurse midwives
- Licensed midwives
- Doula providers
- Psychologists
- Licensed professional clinical counselor
- Licensed clinical social workers
- Licensed marriage and family therapists

In instances where the Network Provider is reimbursed on a per-service basis, this requirement applies at the procedure code level. Primary Medical Groups (PMG) / Independent Physician Associations (IPA) must adhere to the requirements outlined in APL 25-012 and reimburse network providers at no less than the TRI Fee Schedule rate for dates of service on/after January 1st, 2024. Anthem may require and rely upon attestations and supporting documentation by their Subcontractors and Downstream Subcontractors to ensure compliance with APL 25-012.

FQHC and RHC services do not qualify for reimbursement under the TRI Fee Schedule and thus are not qualifying services for the purposes of this directed payment arrangement. FQHC and RHC services are subject to reimbursement in accordance with the FQHC/RHC Payment Parity Requirement" inclusive of the TRI minimum fee schedule requirements established by this APL for applicable services furnished by eligible network providers.

APL 25-012 does not obligate Anthem to pay eligible network providers that historically received payment for applicable services at a set percentage of the legacy Medi-Cal fee schedule rates to continue to pay the same percentage of the TRI Fee Schedule rates.

Out-of-network Providers

Anthem must reimburse specified services billed and rendered by eligible out-of-Network providers (including, but not limited to, family planning, sexually transmitted diseases services, human immunodeficiency virus testing and counseling, and Minor Consent Services) at no less than the Medi-Cal FFS Rate. In the event that a service rendered in one of the above qualifying benefit categories and no Medi-Cal FFS rate is available, Anthem will reimburse at the applicable TRI Fee Schedule rate.

Comprehensive Family Planning Services (SB94)

Enhanced rates for specified evaluation and management procedure codes when used for comprehensive family planning services inclusive of alternative conversion factors required by Senate Bill 94 pursuant to page 3g of Attachment 4.19-B of the California Medicaid State Plan, and Proposition 56 supplemental payments pursuant to page 4 of Supplement 27 to Attachment 4.19-B of the California Medicaid State Plan became effective January 1, 2024.

Anthem has a formal procedure for the acceptance, acknowledgment, and resolution of Provider grievances related to the processing or non-payment of a directed payment. The provider claims dispute process is communicated in the claim payment dispute section of this manual.

Additional guidance related to TRI can be found on the at dhcs.ca.gov/medi-cal-targeted-provider-rate-increases-and-investments.

Providers may send their TRI related inquiries to our shared mailbox at TRI_Inquiry@Anthem.com.

Chapter 17: Grievances, Appeals, Disputes

Providers have the right to file a dispute with Anthem for denial, deferral or modification of a claim disposition or post-service request.

Providers also have the right to appeal on behalf of a member for denial, deferral or modification of a prior authorization or request for concurrent review. These appeals are treated as member appeals and follow the member appeals process.

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

Provider grievances and appeals are classified into the following two categories:

1. Grievances relating to the operation of the plan including benefit interpretation, claim processing and reimbursement
2. Provider appeals of claim determinations including medical reviews related to adverse benefit determinations

Member grievances and appeals can include but are not limited to the following:

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

Claim Payment Dispute

If you are not satisfied with the outcome of a claim payment decision, you may begin the claim payment dispute process.

The claim payment dispute process consists of the following **linear** steps:

1. Reconsideration
2. Claim payment appeal

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

Claim Inquiries

Claim Inquiry: A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but the outcome of the claim inquiry may result in the initiation of the claim payment dispute via the web or via written communication as noted below. Claim payment disputes will not be taken over the phone.

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

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

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

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

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

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

Claim Payment Reconsiderations

Anthem encourages you to submit a claim reconsideration if you believe a claim was not processed correctly. Please submit your request for claim reconsideration in writing and include all pertinent information that will help us understand the issue. **We must receive your request for reconsideration within 12 months of the last action on a claim.**

Upon receipt of your reconsideration request, an acknowledgement letter will be sent to you within 15 business days of our receipt. We will conduct an internal review that includes a thorough investigation of the claim payment by a trained analyst utilizing all applicable statutory, regulatory, contractual and provider subcontract provisions, Anthem policies and procedures, and all pertinent facts submitted from all parties.

The results will then be communicated to you in a determination letter within 30 calendar days of the receipt of the reconsideration. If the outcome of the reconsideration requires an adjustment to a claim payment, the adjustment will take place within 5 business days of the reconsideration decision.

Claim Payment Appeal

If you are unsatisfied with the outcome of the reconsideration, you may submit a claim payment appeal within **60 calendar days** of the reconsideration outcome. Please submit your claim payment appeal in writing and please include as much information as is pertinent to help us better understand why you are appealing the decision.

A provider has **30 calendar days** to resubmit the appeal when missing information is requested.

Note: Some providers may have additional time to submit an appeal based upon their contract with Anthem.

Upon receipt of your claim payment appeal, an acknowledgement letter will be sent to you within 15 business days of our receipt. We will conduct an internal review that includes a thorough investigation of the appeal by a trained claims appeal analyst utilizing all applicable statutory, regulatory, contractual and provider subcontract provisions, Anthem policies and procedures, and all pertinent facts submitted from all parties.

The results will then be communicated to you in a determination letter within 30 calendar days of the receipt of the claim payment appeal. If the outcome of the claim payment appeal requires an adjustment to a claim payment, the adjustment will take place within 5 business days of the reconsideration decision.

It is important for hospitals, doctors, and other providers to be paid promptly, therefore DMHC offers a Provider complaint submission process. After completing 45 business days of Anthem's claim reconsideration process and dissatisfied with the outcome, providers can submit a provider complaint to DMHC. The provider complaint can also be used when Anthem has failed to act within the deadlines set above.

Providers may contact the DMHC provider complaint toll free number at **877-525-1295**.

Submission of Disputes

Online (for reconsiderations and claim payment appeals): Use the secure provider Availity Appeal application at Availity.com. Through Availity Essentials, you can upload supporting documentation and receive immediate acknowledgement of your submission.

For Appeals, your Availity Essentials user account will need the Claim Status role. To Send Attachments from Claim Status, you'll need the Medical Attachments role.

Locate the claim you want to dispute on Availity Essentials using Claim Status from the Claims & Payments menu. If available, select **Dispute Claim** to initiate the dispute. Go to Request to navigate directly to the initiated dispute in the appeals dashboard add the documentation and submit.

You may use the **Provider Resolution Request form** on our website at providers.anthem.com/CA to submit a reconsideration or claim payment appeal.

Mail requests for reconsideration or claim payment appeals to:

Claims Payment Reconsideration Department
Anthem
P.O. Box 60007
Los Angeles, CA 90060-0007

Required Documentation for Claims Payment Disputes

Anthem requires the following information when submitting a claim payment dispute (reconsideration or claim payment appeal):

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

Provider Grievances

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

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

Provider grievances may be filed up to 180 calendar days from the date the provider became aware of the issue.

If a provider or member has a grievance, Anthem would like to hear from them either by phone or in writing. Grievances may be filed by contacting your provider relationship management representative or in writing and submitted to the Grievance and Appeal department or contacting their provider Experience Manager. Providers may file a written grievance by using the Physician/Provider Grievance form located on our website at providers.anthem.com/CA.

Mail the form to the following address:

Grievance and Appeal Department
Anthem
P.O. Box 60007
Los Angeles, CA 90060-0007

Providers can also fax the form to **866-387-2968**.

Anthem will send a written acknowledgement to the provider within **five calendar days** of receiving a grievance. We may request medical records, or an explanation of the issues raised in the grievance in the following ways:

- By telephone
- By fax with a signed and dated letter
- By mail with a signed and dated letter

The timeline for responding to the request for more information is as follows:

- Standard grievances: Providers must comply with the request for additional information within **10 calendar days** of the date that appears on the request.
- Providers are notified in writing of the resolution including their right of appeal if any. According to state law, we may not be able to disclose the final disposition of certain grievances due to peer review confidentiality laws.
- Anthem sends a written resolution letter to the provider within **30 calendar days** of the receipt of the grievance.
- Grievances are tracked and trended, resolved within established time frames, and referred to peer review when necessary. The Anthem grievance and appeal process meets all requirements of state law and accreditation agencies.

Note: Anthem offers an expedited grievance and appeal process to members for decisions involving urgently needed care. Whether standard or expedited, grievances and appeals are reviewed by a person who is not subordinate to the initial decision-maker.

Arbitration

If the provider is not satisfied with the outcome of a review conducted through the provider appeal process, there are additional steps that can be taken through arbitration in accordance with the Anthem State Sponsored Business Provider Agreement.

For more information, call the appropriate Customer Care Center at the contact numbers listed in Chapter 2: Quick Reference of this manual.

Independent Review Organization

Certain facilities have an agreement with Anthem Blue Cross that requires that all medical necessity disputes (length of stay, level of care, or whether a procedure is investigational/ experimental) are to be resolved through a binding determination to be made by an IRO. If the Agreement with Anthem Blue Cross contains this dispute resolution provision and the claim involves one where Anthem Blue Cross performs the utilization management and facility appeal/facility dispute resolution function for the claim in dispute, facilities are still required to first submit the dispute through an appeal made in accordance with the provider and facility dispute resolution process described above.

Further, if the agreement with Anthem Blue Cross contains this dispute resolution provision, facilities may not submit medical necessity disputes for those claims to arbitration. Instead, for all medical necessity disputes for those claims, the facility shall adhere to the Process below for a binding, final resolution of the dispute to be made by an IRO. If the claim in dispute is not one where **Anthem Blue Cross performs the utilization management and facility appeal/facility dispute resolution functions, then this IRO process does not apply.**

1. For each disputed medical necessity claim where Anthem Blue Cross performs the Utilization Management and facility appeal/facility dispute resolution function for the claim in dispute, the facility shall complete and submit to Anthem Blue Cross a Facility Binding Independent Review Organization (IRO) Request form. The form must be completed in its entirety.
    - The form is also available at anthem.com/docs/public/inline/P_CA_00097.pdf.
2. The completed form shall be mailed to: Anthem Blue Cross, Risk Unit AC-6C, P.O. Box 60007, Los Angeles, CA 90060-0007;
3. A separate form must be completed and submitted for each disputed medical necessity claim;
4. The facility may select one IRO to be used from a list of two or more IROs that Anthem Blue Cross will identify on the IRO Request form;
5. All submissions made pursuant to this section shall be made within the timeframe set forth in the Agreement with Anthem. If no timeframe is set forth in the Agreement with Anthem, then the submission of a medical necessity dispute to the IRO process shall be made no later than 365 days following an adverse determination made by Anthem Blue Cross in the Provider Dispute Resolution process;
6. Once an IRO Request is submitted, Anthem Blue Cross will submit the Request, along with all medical records previously submitted by the facility to Anthem Blue Cross, to the IRO designated by the facility. The facility may not submit additional medical records in conjunction with the IRO Request. It is required that all medical records necessary for Anthem Blue Cross to make a medical necessity determination is to have been submitted by the facility no later than its appeal to Anthem Blue Cross in the Provider Dispute Resolution Process;
7. When the designated IRO makes its determination, copies of the written determination will be transmitted to both Anthem Blue Cross and the facility;
8. If the IRO rules either in whole, or in part, in favor of the facility, Anthem Blue Cross will directly adjust and pay the claim through its Claims system in accordance with the determination made by the IRO.
9. Unless the Agreement with Anthem Blue Cross provides otherwise, the cost of the IRO shall be equally divided between Anthem Blue Cross and the facility.

Member Appeals and Grievances

We encourage Anthem members to seek resolution of issues through our grievance and appeal process. The issues may involve dissatisfaction or concern about a contracted provider or the plan.

Note: Anthem does not discriminate against members for filing a grievance or an appeal. Providers are prohibited from penalizing a member in any way for filing a grievance.

To help ensure that our members' rights are protected, all Anthem members are entitled to a grievance and appeal process.

Members may file a grievance not related to a Notice of Adverse Benefit Determination at any time or an adverse benefit determination appeal within 60 calendar days from the date on the Notice of Action letter by calling our Customer Care Center at:

Location	Medi-Cal Customer Care Center
L.A. County	**888-285-7801** Monday to Friday, 7 a.m. to 7 p.m.
Outside L.A. County	**800-407-4627** Monday to Friday, 7 a.m. to 7 p.m.
TTY	**888-757-6034** (**TTY 711**)

If a member wants to file a grievance, the process is to call the Customer Care Center, write a letter to the Grievance and Appeal department, or fill out a Member Grievance form and mail it to us, telling us about the problem.

Mail the grievance form to:

Grievance and Appeal Department
Anthem
P.O. Box 60007
Los Angeles, CA 90060-0007

Grievance forms are available at the places where members receive their healthcare, such as their PCP's office, as well as on our website at mss.anthem.com/california-medicaid/benefits/member-materials.html:

1. Select **Other Resources** (drop-down menu in the bottom right of the page).
2. Select the language of the Member Grievances form.

A person does not need to be a member to file a grievance or request an appeal. With written permission, authorized representatives can file on behalf of the member either orally or in writing. In the event of an expedited appeal, the member's written permission is not required for a provider to file the appeal request on behalf of a member. This may include the following:

- Relative
- Guardian
- Conservator
- Attorney
- Member's provider

The grievance submission must include the following information:

- Who is part of the grievance
- What happened
- When it happened
- Where it happened
- Why the member was not happy with the healthcare services
- Attach documents that will help us investigate the problem

Providers and IPA/PMGs are required to provide Anthem with medical records within seven calendar days of the request (or sooner if an expedited grievance).

If the member cannot mail the form or letter, we will assist the member by documenting a verbal request.

Note: If the member's grievance is related to an **adverse benefit determination** already taken, it is considered an **appeal**.

Adverse benefit determinations may include the following:

- Denial or limited authorization of a requested service including the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or in part, of payment for service
- Failure to provide services in a timely manner as defined by the state
- Failure of Anthem to act within required time frames

Filing Timelines for the member grievance and appeal process:

Member grievance	Anytime
Member appeal: Medi-Cal	60 calendar days after the date of the letter notifying the member of a denial, deferral, or modification of a request for services

Note: Anthem will resolve any grievance or appeal, internal or external, at no cost to the member. Interpreter services and translation of materials into non-English languages and alternative formats are available to support members with the grievance and appeal process at no cost to the member.

Member Grievances and Appeals: Acknowledgement

After we receive a member's request, we will send an acknowledgment letter within **five calendar days** from the date we receive it.

If we receive a request for an expedited grievance or appeal, a clinical nurse will review the request to determine if the request involves an imminent and/or serious threat to the health of the member including, but not limited to, severe pain and potential loss of life, limb, or major bodily function. This determination is made within one working day of the receipt of the expedited request.

When a clinical nurse determines that a case meets the criteria to be handled as an expedited or standard request, attempts to notify the member of the decision are made by telephone. In addition, an acknowledgement letter is sent to the member indicating the decision to handle as expedited or standard.

If a request is determined to be appropriate for expedited handling, the acknowledgement letter includes the member's right to immediately notify the Department of Managed Health Care (DMHC) of the expedited appeal and informs the member of the time available for providing information and that limited time is available for expedited appeals.

During the appeal process, Anthem will provide the member a reasonable opportunity to submit comments, present evidence and testimony, and make legal/factual arguments in person as well as in writing relevant to the appeal. The member will be informed of the limited time available to exercise this right. If a member fails to submit information by the specified deadline, it is noted in the member case file.

Member Grievances and Appeals: Resolution

Anthem may request additional information from the providers involved by phone, mail, or fax. The requests may include a request for additional medical records or an explanation from the provider(s) involved in the case. Providers are expected to comply with requests for additional information within 10 calendar days for standard grievances and appeals and within 24 hours for an expedited grievance or appeal.

The member will receive a Grievance Resolution Letter within 30 calendar days of the date we received the grievance.

Standard appeals are resolved within 30 calendar days from the date of receipt of the request. Members are notified in writing of the appeal resolution including their right to further appeal if any. The request for an appeal may be made orally but must be followed up with a written request.

If a grievance remains unresolved for more than 30 calendar days, not accepted, or a member need assistance, the member has the right to contact DMHC for assistance at **888-466-2219 (TTY 877-688-9891)** or dmhc.ca.gov.

Within 120 calendar days of the Notice of Appeal Resolution (NAR) form, Medi-Cal Members have the right to request a State Hearing. For more information about State Hearing requests, Members may call the California Department of Social Services (CDSS) at **800-952-5253 (TTY 800-952-8349)**.

Anthem resolves expedited appeals as quickly as possible and within 72 hours. The member is notified by telephone of the resolution, if possible, and is also sent a written resolution letter within **72 hours** from receipt of the appeal request.

Other Options for Filing Grievances

Members may submit a request to the following entities:

- Medi-Cal Managed Care Office of the Ombudsman at the California Department of Health Care Services

Independent Medical Review

After exhausting the Anthem grievance and appeal process, if a member is still dissatisfied with a decision, the member has the right to request an independent medical review (IMR) from the following entities:

- California Department of Managed Health Care: Members may request an IMR if eligible for an expedited review or an urgent grievance or appeal.

Note: If the member has requested a state hearing, they cannot also request an IMR.

Medi-Cal Member Appeals: State Hearing

The state hearing process is applicable to Medi-Cal enrollees only.

Medi-Cal members may request a state hearing with the California Department of Social Services (CDSS) after exhausting the Anthem appeal processes, or if Anthem fails to resolve an appeal request within the required standard and expedited appeal time frames.

The state hearing must be filed within 120 days from the date of the "Notice of Appeal Resolution". If the member is currently getting treatment and wants to continue with that treatment, they must ask for a state hearing within 10 days. Members can ask for a State Hearing in the following ways:

The request may be submitted toll-free by fax at **833-281-0903** or mailed to the state of California at:

Department of Social Services
State Hearing Division
744 P Street, Mail Station 19-17-37
Sacramento, CA 95814

By calling the department at **800-743-8525**. TDD users, call **800-952-8349**

Or submitting an online request at cdss.ca.gov > **Request Hearing**.

Note: An IMR with the Department of Managed Health Care (DMHC) may not be requested if a state hearing has already been requested for a Notice of Adverse Benefit Determination.

Once the state receives the member's request, the process is as follows:

- The state sends a notice of the hearing request to Anthem.
- Upon receipt of the request, all documents related to the request are forwarded to the state.
- 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 the witnesses and offer rebutting evidence.
- Members have the right to represent themselves, be represented by a legal counsel or an Authorized Representative (relative, friend, advocate, or doctor) at the State Hearing. (the member must let the State Hearing Division know that someone else is speaking on their behalf)
- An administrative law judge renders a decision in the hearing within 90 business days of the date the hearing request was made.
- If the judge overturns the Anthem position, we must adhere to the judge's decision and ensure that it is carried out.

Member Grievances and Appeals: Discrimination

Members who contact us with an allegation of discrimination are immediately informed of the right to file a grievance. This also occurs when one of our representatives working with a member identifies a potential act of discrimination. The member is advised to submit an oral or written account of the incident and is assisted in doing so if they request assistance.

We document, track, and trend all alleged acts of discrimination. A Grievance and Appeal associate will review and trend cultural and linguistic grievances in collaboration with a cultural and linguistic specialist.

Medi-Cal Member Appeals: Continuation of Benefits for Anthem Members during an Appeal

Medi-Cal members may continue benefits while their appeal or state hearing is pending in accordance with federal regulations when all the following criteria are met:

- A member or his provider on the member's behalf must request the appeal within 10 days of our mail date of the adverse action notification or prior to the effective date on the written notice of the adverse action.
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- Services were ordered by an authorized provider.
- The original period covered by the initial authorization has not expired, and members request extension of benefits.

Chapter 18: Compliance & Regulatory Requirements

Provider's Role in Compliance, Ethics, Privacy, and Hotline Reporting

Disease Surveillance

All health facilities, clinics or other provider settings where more than one healthcare provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to both local and State public health authorities. This is essential for disease control and public safety. Delay or failure to report has contributed to preventable secondary transmission and disease outbreaks in the past.

Providers must provide all medical records or information as requested and in the time frame established by state and federal laws. Certain diseases and situations are considered emergencies and must be reported immediately.

Reports must be submitted to the local health department (LHD) of the patient's jurisdiction of residence. For more information on each counties LHD, go to the California Department Public Health, LHD Communicable Disease Contact Information website.

If unable to reach the LHD, Healthcare providers may contact the CDPH Duty Officer at **(916) 328-3605**.

California Health and Human Services Data Exchange Framework

To ensure that every Californian, as well as the health and human service and governmental entities who serve them, can access information needed to provide safe and effective care, providers shall comply with all state requirements regarding electronic health record data exchange. DxF advances health equity for all Californians by facilitating the secure and appropriate exchange of health and social services information.

Standards of Ethical business Conduct

The Anthem values drive our ethics program, and we expect our providers to embody these same values as you interact with our members.

The Anthem core values are:

- Leadership — Redefine what's possible.
- Community — Committed, connected, invested.
- Integrity — Do the right thing, with a spirit of excellence.
- Agility — Deliver today – transform tomorrow.
- Diversity — Open your hearts and minds

You may call the Anthem Ethics and Compliance Help Line to report potential misconduct at **877-725-2702**.

Anthem's Code of Conduct is located at s201.q4cdn.com/332696633/files/doc_governance/Elevance-Health-July-2022-Code-of-Conduct-final.pdf.

Anthem Compliance Program

Compliant operations help our members receive the care they need. We have robust processes and oversight of our operations, and we expect the same from our providers.

Anthem follows the 7 Elements of an effective compliance program. One of those elements is auditing and monitoring. We routinely monitor a variety of processes including grievances and appeals to understand providers' performance.

We also use a risk assessment approach to determine the actions of our compliance associates. If our risk assessment or monitoring indicates potential noncompliance, we will conduct an investigation. When there is a compliance violation, we require a corrective action plan with management actions that mitigate risks and prevent further occurrence. As part of any investigation, we require that providers cooperate with the investigation and provide access to pertinent member records.

The Department of Health and Human Services, Office of Inspector General (OIG) has published a notice to assist physician practices in developing a voluntary compliance program:

- OIG Compliance Program for Individual and Small Group Physician Practices at oig.hhs.gov/authorities/docs/physician.pdf.

Screening and monitoring Excluded Parties

In our role as a government healthcare program contractor, Anthem may not employ or contract with individuals or companies that are barred from taking part in such programs or receiving funds from such programs.

To meet this obligation, Anthem screens our providers against exclusion lists kept by the OIG, General Services Administration (GSA) and the Department of Health Care Services (DHCS) Suspended and Ineligible Provider List. We expect our providers to also screen and monitor their staff on a regular, periodic basis. Providers should notify Anthem within 10 working days of removing a suspended, excluded, or terminated provider from its provider network.

State and Federal Requirements

Network providers and subcontractors of Anthem are responsible for ensuring all applicable state and federal laws and regulations, Contract requirements, and other DHCS and DMHC guidance, including but not limited to DHCS and DMHC All Plan Letters (APLs), Policy Letters, Senate Bill (SB), Assembly Bills (AB) and California Code of Regulations (CCR) are followed. Non-compliance with those regulations will result in a corrective action plan (CAP), including, but not limited to, sanctions and/or a breach of contract notice.

Professional and Respectful Communication Standards

Anthem maintains an ongoing commitment to fostering a respectful, collaborative, and professional environment, recognizing that effective communication is an integral component. Your Participating Provider Agreement (the "Agreement") with Anthem outlines your obligations as a participating provider with Anthem regarding conduct and professionalism. Providers, including those who represent them, such as office staff, billing entities, are expected to conduct themselves in a professional and respectful

manner in all interactions with Anthem members, employees, and representatives. Professional and respectful communication is not just a courtesy, but a fundamental responsibility that supports collaboration, builds trust, and enhances the quality of service we offer to our members. By upholding these standards, providers contribute to a positive and inclusive atmosphere where every individual feels valued and respected.

In addition to the standard policies and guidelines outlined in this manual and your participating Provider Agreement, Anthem maintains a zero-tolerance policy for abusive or disruptive behavior, whether physical or verbal, from providers, or those representing providers, during the course of business. Violent acts and/or continued abusive or disruptive behavior will result in the termination of your participation in Anthem's provider network.

Examples of behavior that will not be tolerated include, but are not limited to, any act of violence, threats, harassment, intimidation, and other disruptive behavior. Such behavior can include actual physical injury, direct or indirect verbal or written statements, disruptive behavior, suggestions of self-harm, threats of retaliation to others, or gestures that communicate a threat of physical harm.

Marketing Rules

The delivery of quality healthcare poses numerous challenges, not least of which is the commitment shared by Anthem and its providers to protect our members.

Anthem wants its members to make the best healthcare decisions possible for themselves and their families. And when they ask for our assistance, we want to help them make those decisions without undue influence.

Anthem follows strict enrollment and marketing guidelines created by the California DHCS.

Enrollment Policies

Anthem providers may not market directly to individuals or families.

An example of direct marketing that is not allowed is mailing to individual patients any Anthem or other health plan material in which they are told to join Anthem or another plan.

All information that prospective members receive about our healthcare plan comes from the state or from marketing activities approved by the California DHCS. The state must approve any marketing materials we create.

Providers may distribute information about our healthcare plan after receiving a specific member request for more information on our benefits and services.

Note: As a network provider, you may not provide prospective members with an Enrollment form; you may only assist Anthem members (who are patients) in completing the Enrollment form.

Marketing Policies

Anthem providers are prohibited from making marketing presentations and advising or recommending to an eligible individual that they select membership in a particular plan.

DHCS marketing practice policies prohibit network providers from making the following false or misleading claims:

- That the PCP's office staff are employees or representatives of the state, county, or federal government
- That Anthem is recommended or endorsed by any state or county agency or any other organization
- That the state or county recommends that a prospective member enroll with a specific healthcare plan
- That a prospective member or medical recipient will lose benefits under the Medi-Cal program 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 or allowing Anthem representatives to make marketing presentations to prospective members.
- 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 that is 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 obtained originally for enrollment purposes from confidential state or county data sources or from the data sources of other contractors.
- Employing marketing practices that discriminate against potential members based on marital status, age, religion, sex, gender identity, national origin, language, sexual orientation, ancestry, pre-existing psychiatric or medical conditions (such as pregnancy, disability or acquired immune deficiency syndrome), other than those specifically excluded from coverage under our contract.
- Reproducing or signing an enrollment application for the member.
- Displaying materials only from the provider's contracted managed healthcare organizations and excluding others.
- Engaging in any marketing activity on behalf of Anthem on state or county premises or at event locations such as health fairs and festivals, athletic events, recreational activities, and plan-sponsored events.

Providers are permitted to:

- Distribute copies of applications to potential members.
- Assist members in finding out what programs they qualify for and then direct them to call appropriate resources for more information.
- 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 17: Grievances, Appeals, Disputes of this manual for more information).

Note: Providers are required to obtain approvals prior to using patient-focused and Anthem-branded marketing materials created by your office. Before distributing materials to your Medi-Cal patients, submit your materials to Anthem through your local Community Relations Representative. We will review and seek approval from the following agencies as appropriate:

- L.A. Care Health Plan (L.A. County)
- Department of Health Care Services (DHCS)
- Department of Managed Health Care (DMHC)
- Other stakeholders as required

HIPAA Privacy, PHI, Security

The Anthem Health Insurance Portability and Accountability Act of 1996 (HIPAA) Web Privacy Statement and additional information about privacy and security policies and procedures can be found under *Provider Resources* of our website at anthem.com/ca/privacy.

Anthem uses a secure email encryption tool to ensure that member's protected health information (PHI) is kept private and secure and to help prevent identity theft. Secure email encrypts emails and attachments that it identifies as potentially having PHI. Providers can also use secure email to send encrypted email to Anthem when they respond to an Anthem-encrypted email.

Anthem expects that member PHI and PII (Personally Identifiable Information) is assiduously guarded and under strict security in your offices. Security for hard copy records and files must adhere to stringent confidentiality standards that meet or exceed the HIPAA regulations and California statutes related to information security. Also, unauthorized parties must not be allowed to view Anthem members' PHI or PII.

When you travel from the Anthem website to another website, whether through links provided by Anthem or otherwise, 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.

Misrouted Protected Health Information

Providers and facilities are required to review all member information received from Anthem to ensure no misrouted PHI is included. Misrouted PHI includes information about members that a provider or facility is not treating. PHI can be misrouted to providers and facilities by mail, fax, email, or electronic remittance advice.

Providers and facilities are required to destroy immediately any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or redisclose misrouted PHI.

If providers or facilities cannot destroy or safeguard misrouted PHI, please contact the appropriate Customer Care Center located in Chapter 2: Quick Reference.

Fraud, Waste, and Abuse

Anthem Fraud, Waste, and Abuse Hotline: **888-231-5044**

Understanding Fraud, waste, and Abuse

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

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

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

Examples of Provider fraud, waste, and abuse

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

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of 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

Examples of Member Fraud, waste, and Abuse

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

- Forging, altering, or selling prescriptions
- Letting someone else use the member's Medi-Cal identification card
- Relocating to out-of-service plan area and not letting us know
- Using someone else's Medi-Cal identification card

Reporting Provider or Recipient Fraud, Waste, and Abuse

If you suspect a provider (for example, provider group, hospital, doctor, dentist, counselor, medical supply company) or an Anthem member has committed fraud, waste, or abuse, **you have the right to report it**. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so.

You can report your concerns by:

- Visiting our fighthealthcarefraud.com education site; at the top of the page select **Report it** and complete the Report Waste, Fraud and Abuse form
- Calling our SIU fraud referral hotline at **888-231-5044**

The name of the person reporting the incident and their callback number will be kept in confidence by investigators of the Special Investigations Unit (SIU) to the extent possible by law.

Other Ways You Can Report Medi-Cal Fraud

- Mail a written complaint to:

  Department of Health Care Services
  P.O. Box 997413
  Sacramento, CA 95899-7413
- Call the Medi-Cal fraud hotline **(800) 822-6222**.

When reporting possible fraud, waste, or abuse involving a **provider** (a doctor, dentist, counselor, medical supply company), include:

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

When reporting possible fraud, waste or abuse involving a member include:

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

Anonymous Reporting of Suspected Fraud, Waste, and Abuse

Any incident of fraud, waste or abuse may be reported to us anonymously; however, our ability to fully investigate an anonymously reported matter may be handicapped. As a result, we encourage you to provide as much detailed information as possible.

Investigation Process

We investigate all reports of fraud, waste, and abuse. Allegations and the investigative findings are reported to the California Department of Health Care Services (DHCS), regulatory and law enforcement agencies, as appropriate. In addition to reporting, we take corrective action such as:

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

If you are working with the SIU, mail all checks and correspondence to:

Anthem
Special Investigations Unit
740 W Peachtree Street NW
Atlanta, Georgia 30308
Attn: investigator name, #case number

Paper medical records and/or claims are a different address, which is supplied in correspondence from the SIU. If you have questions, contact your investigator. Delays for claim and/or medical record review, and ultimately resolution of an investigation may be delayed if SIU-supplied instructions are not followed. An opportunity to submit claims and/or supporting medical records electronically is an option if you register for an Availity Essentials account. Contact Availity Client Services at **800-AVAILITY (282-4548)** for more information.

About Prepayment Review

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

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

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

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

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

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

Acting on Investigative Findings

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

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

SIU follows the overpayment and recovery guidelines set forth in section 14.9; and participating providers who are not responsive may potentially have their overpayment deducted from future claim payments.

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

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

False Claims Act, False Statements Act, Stark Law

We are committed to complying with all applicable federal and state laws including the federal FCA.

It should be noted that under federal law (in other words, the False Claims Act (FCA), Title 31 U.S.C. 3729 et seq.), anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for up to three times the damages or loss to the government plus civil penalties of $5,500 to $11,000 per false claim.

The FCA is a federal law that allows the government to recover money stolen through fraud by government contractors. Under the FCA, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages or loss to the government plus civil penalties of $5,500 to $11,000 per false claim.

The FCA also contains **qui tam** or whistleblower provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under qui tam provisions in the FCA and may be entitled to a percentage of the funds recovered by the government.

The False Statements Accountability Act prohibits anyone from making false statements or representations (written or oral) or withholding material information relating to a government contract and other matters under the jurisdiction of the federal government.

The Stark Law is an anti-referral statute that is directed specifically at physicians and prohibits them from making referrals for designated health services to an entity with which they or an immediate family

member have a financial relationship. The definitions of referral, designated health service, entity and financial relationship are all quite broad.

All providers are advised to seek their own counsel to ensure no referral is made in violation of the Stark Law.

Delegation Oversight

The Anthem Delegation program is designed to ensure quality of care and service by contracted entities with delegated functions prior to delegating any function and to ensure compliance with all federal, state, accreditation, and organizational requirements (CMS, DMHC, NCQA), related to each delegated function.

Described within the Delegation Oversight Program is the process by which Anthem operates an objective and systematic review of the delegated functions in a consistent manner for all contracted networks or entities with delegated responsibilities.

Anthem may delegate to a qualified provider group/entity the authority to perform selected medical management and administrative functions on its behalf. In carrying out these functions, the qualified contracted provider group/entity is expected to perform such functions in a manner that is consistent with all Anthem standards, state and federal legislation, regulations, and accreditation organization standards. It's important they establish policies, including UM/CR denial system controls, and implement processes to safeguard and monitor data against unauthorized modification.

The qualified contracted provider group/entity is expected to comply with all requirements of network adequacy standards established in DHCS' All Plan Letter for Network Certification Requirements. This includes APL 23-001 and its Attachment A: Network Adequacy Standards, plus APL 21-003 Provider Terminations. DHCS established requirements to evaluate the ability to provide medically necessary services needed for anticipated membership and utilization. The geographic requirements are provided for time or distance from a member's residence to a contracted provider for primary care, specialty care, obstetrics/gynecology primary care, obstetrics/gynecology specialty care, hospitals, pharmacy, and mental health (non-psychiatry) outpatient services.

Additionally, the qualified contracted provider group/entity is expected to meet or exceed the mandatory full-time equivalent (FTE) provider-to-member ratio for PCPs: notably, one primary care provider to every 2,000 members, and a total network physician ratio of one FTE physician to every 1,200 members.

As per the Anthem contract with DHCS, Anthem is held accountable and liable for all the Plan's administrative and operational functions. The delegated group/entity is additionally expected to strictly comply with all the requirements of the Plan's DHCS contract.

While delegation is granted, the Plan retains full accountability, overall responsibility, and the right to monitor and rescind the delegation function, if necessary.

To assert Compliance & Oversight, Anthem will perform or require the following as part of their oversight of the delegated medical group:

- Pre-contractual audit before delegating utilization management, claims processing, and/or credentialing functions, including providing a description of their UM/CR systems controls to protect and monitor data from unauthorized modifications.
- An initial audit (Post-Go-Live audit) within 90 - 120 calendar days after the contract effective date to measure compliance with Anthem's standards.
- An annual audit of the delegated medical group to help ensure continued compliance with accreditation, state, and federal regulations.
- A focused or off-cycle audit based on specific activity, as necessary.
- Sanctions or revocation of delegated UM duties for continued non-compliance with Anthem standards.
- Delegate development and implementation of corrective action plan when the medical group is non-compliant with Anthem standards.
- Generate required reports as outlined in the delegation agreement that meet applicable regulatory requirements and accreditation standards.

Provider Group Financial Oversight

In accordance with Anthem HMO Finance Policies and Procedures, the Medical Services Agreement and the California Solvency Regulations, capitated provider organizations are required to submit to Anthem their quarterly and annual audited financial statements pursuant to GAAP within the same time frame as mandated under Sec 1300.75.4 of Title 28 of the California Code of Regulations.

Anthem reviews financial data trends using Anthem financial viability standards noting any particular material changes in financial condition and unusual balances. Also, Anthem requires that soft copies of the provider organization’s DMHC formatted quarterly, and annual financial survey reports must also be provided to Anthem.

The depth of the analysis is based on the level of financial risk of the provider organization as determined pursuant to Anthem Financial Oversight Policies and Procedures. In the event the provider organization does not meet any of the solvency regulations and Anthem financial viability standards, the provider organization shall within 30 days upon request by Anthem provide a Standby Letter of Credit (SL/C) as a security reserve in an amount acceptable to Anthem to mitigate risk.

If the provider organization relies on parent or a sponsoring entity's financial support to meet DMHC financial solvency criteria for more than two consecutive quarters, or the provider organization has large frequent unsecured affiliates' receivables, upon request by Anthem, the provider organization shall within 30 days provide Anthem with its parent or the sponsoring entity's most recent financial auditor reports and statement.

Anthem minimum financial viability standards include the following:

- Cash ratio of at least 90% (cash and/or equivalents plus marketable securities divided by total current liabilities)
- Total stockholders' tangible net equity must be equal to or greater than 2% of provider group's annualized healthcare revenues or 8% of annualized non-capitated medical expenditures, whichever is greater
- DMHC requires tangible net equity be 1% of annualized revenues, or 4% of annualized non-capitated medical expenditures, whichever is greater
- Maintain a working capital ratio of at least 1.5:1
- Maintain a debt-to-equity ratio of not more than 200%
- Provision for incurred but not reported (IBNR) claims liability of at least two months of average annual claims expenses or based on the actuarial estimate endorsed by a CPA firm or by a third actuary party
- Days cash on hand (DCOH) must at least be 60 days

Anthem reserves the right to amend the financial viability standards as indicated above. Hence, upon its discretion Anthem shall add to, delete from, and otherwise modify any part of the P&P at any time.

Medical Loss Ratio

Subcontractors' MLR Reporting and Remittance Obligations
Subcontractors are contractually obligated annually to report a Medical Loss Ratio (MLR) to Anthem, regardless of meeting materiality threshold. Reporting templates and education on how to complete the templates will be provided.

Pursuant to APL 24-018, 42 CFR sections 438.8 and 438.230(c) and Paragraph 11 of the 1915(b) CalAIM Special Terms and Conditions (STCs), which include, but are not limited to, the requirements in:

A. STC downstream requirements and the DHCS preferred determination tool;
B. For the MLR Experience Defined;
C. For the Materiality Threshold;
D. For the MLR numerator and incurred claims for Subcontractors and Downstream Subcontractors;
E. For remittances received by Subcontractors and Downstream Subcontractors must be deducted from incurred claims;
F. For remittances paid by Subcontractors and Downstream Subcontractors must be excluded from incurred claims;
G. For MLR denominator;
H. For Subcontractor and Downstream Subcontractor allocation of expenses;
I. For Subcontractor and Downstream Subcontractor credibility adjustments;
L. For general MLR reporting requirement imposed on Subcontractors and Downstream Subcontractors;
M. For Subcontractor and Downstream Subcontractor reporting
N. For Subcontractor and Downstream Subcontractor MLR submission accuracy attestation;
O. For requirements for Subcontractor and Downstream MLR submissions and oversight requirements;
P. For newer experience exemptions for Subcontractors and Downstream Subcontractors;
Q. For Subcontractor and Downstream Subcontractor re-reporting requirements following a retroactive change to the Capitation Payments for a MLR reporting year.

J. For materiality threshold;
K. For Subcontractor and Downstream Subcontractor MLR reporting at Subcontractor or Downstream Subcontractor arrangement level by county or rating region;
R. For Subcontractor and Downstream Subcontractor remittance requirements; and
S. For Subcontractor and Downstream Subcontractor audit and record retention requirements.

Agreements with LHDs
Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with LHDs must specify the scope and responsibilities of both parties in the provision of services to Members, billing and reimbursements, reporting responsibilities, and how services are to be coordinated between the LHD and the Contractor, including exchange of medical information as necessary.

Agreements with FQHCs, RHCs, Clinics
Subcontractor Agreements, or Downstream Subcontractor Agreements with FQHCs, RHCs, and other clinics also must contain a provision stating that any negotiated and agreed-upon rate with an FQHC, RHC, or other clinic constitutes complete reimbursement and payment in full for the Covered Services rendered to a member.

Hospital Financial Review

Concurrent with Anthem policy to mitigate the risk with capitated provider organizations, a set of hospital financial viability standards are similarly used as analytical guideposts in the evaluation of the capitated hospital's financial capacity as follows:

1. Minimum working capital ratio of 1.10:1
2. Minimum tangible net equity of $5 million (total assets less total liabilities less intangibles)
3. Hospital cash ratio of at least 0.9 (cash and equivalents plus marketable investments, net patient receivables and board designated funds divided by total current liabilities)
4. Days receivable equivalent to 70 days or less
5. Days cash on hand (DCOH) of at least 50 days
6. Positive operating margin

Capitated hospitals are required to provide Anthem with quarterly and annual financial statements based on the same time frames applicable to capitated provider organizations. The timely review of hospital financials would alert Anthem to those experiencing financial difficulties or have emerging financial issues that could adversely impact their financial capacity to fulfill their contractual responsibilities.

Note: at the front-end or pre-contract stage, Anthem may require the applicant hospital to submit a Standby Letter of Credit (SL/C) amounting to a minimum of $300,000 or as may be determined by Anthem Finance in order to mitigate the inherent financial risk. Unlike the capitated provider organization, hospitals are not subject to California solvency regulations.

Carelon Health, Inc. is a separate company providing palliative care services on behalf of the health plan. Carelon Medical Benefits Management, Inc. is a separate company providing utilization review services on behalf of the health plan. Carelon Behavioral Health of California, Inc. is a separate company providing behavioral health services on behalf of the health plan.

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