Provider Manual

Cal MediConnect Plan

Anthem BlueCross

ACAD-PM-0006-21

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CHAPTER 1: INTRODUCTION

Welcome to the Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan)

Welcome to the Anthem Blue Cross Cal MediConnect Plan, a network of dedicated physicians and providers. Anthem Blue Cross (Anthem) has been selected by the California Department of Health Care Services (DHCS) to participate in the Financial Alignment Demonstration called Cal MediConnect. As part of California's Coordinated Care Initiative, the goal of this program is to integrate care for dual-eligible individuals who are enrolled in both the Medicare and Medicaid health plans. By consolidating the responsibility for all the covered services into a single health plan, we expect to see improved quality of care for our members, and improve continuity of care across acute care, long-term care, behavioral health and home-and-community based services using a patient-centered approach.

At Anthem, our goal is to assist you in providing unequaled care to your patients while making the practice of medicine more rewarding; better patient outcomes, better practice economics and diminished practice difficulties. By furnishing the means to accomplish these ends and by helping you and your patients access them, we are confident you will be proud to have joined us.

Service Area

The definition of a service area, as described by the Member Handbook (also called the Evidence of Coverage or EOC), is the geographic area approved by DHCS and the Centers for Medicare & Medicaid Services (CMS) in which a person must live to become or remain a member of the Cal MediConnect Plan. Members who are temporarily away from the service area for a period of six months or less are eligible to receive emergency and urgently needed services outside the service area.

Santa Clara and Los Angeles counties are the service areas for the Anthem Blue Cross Cal MediConnect Plan.

Please visit the **CAREMORE** manual for more information.

There are many advantages to accessing this manual at our website, including the ability to link to any section by selecting the topic in the table of contents. Each section may also contain important phone numbers, as well as cross links to other sections, our website or outside websites containing additional information. Bold type may draw attention to important information.

Legal and Administrative Requirements

Disclaimer

The information provided in this manual is intended to be informative and assist providers in navigating the various aspects of participation with the Anthem Blue Cross Cal MediConnect Plan. Unless otherwise specified in the Provider Agreement, the information contained in this

manual is not binding upon Anthem and is subject to change. Anthem will make reasonable efforts to notify providers of changes to the content of this manual.

This manual may be updated at any time and is subject to change. In the event of an inconsistency between information contained in this manual and the Provider Agreement between you or your facility and Anthem, the Agreement shall govern.

In the event of a material change to the Provider Manual, Anthem will make all reasonable efforts to notify you in advance of such changes through provider bulletins, provider newsletters and other mailings. In such cases, the most recently published information shall supersede all previous information and be considered the current directive.

This manual is not intended to be a complete statement of all Anthem policies or procedures. Other policies and procedures not included in this manual may be posted on our website or published in specially-targeted communications. These communications include, but are not limited to letters, bulletins and newsletters.

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

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

Third Party Websites

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

Privacy and Security Statements

Anthem’s latest privacy and security statements related to HIPAA can be found on the Anthem website. To find these statements, go to **https://mediproviders.anthem.com/ca**.

Please be aware that 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 websites 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 protected health information (PHI) is included. Misrouted PHI includes information about members that a provider or facility is not treating or are not enrolled to your practice. 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 Anthem Blue Cross Cal MediConnect. If you are an Anthem Blue Cross Cal MediConnect Plan provider with questions, use **855-878-1785**, if you're a CareMore provider with questions, call **888-291-1358**.

Collection of Personal and Clinical Information

Anthem will collect and release all personal and clinical information related to members in keeping with California and federal laws, including HIPAA, court orders or subpoenas. Release of records according to valid court orders or subpoenas are subject to the provisions of that court order or subpoena.

The person or entity that is seeking to obtain medical information must obtain the authorization from the member and is to use that information only for the purpose it was requested for, and retains it only for the duration needed.

The individual physician or provider may not intentionally share, sell or otherwise use any medical information for any purpose not necessary to provide health care services to the member.

Only necessary information shall be collected and maintained. Reasons for collecting medical information may include but are not limited to:

- Reviewing for medical necessity of care
- Performing quality management, utilization management and credentialing/recredentialing functions
- Determining the appropriate payment under the benefit for covered services; analyzing aggregate data for benefit rating, quality improvement, oversight activities, etc.
- Complying with statutory and regulatory requirements

Maintenance of Confidential Information

Anthem maintains confidential information as follows:

- Clinical information received verbally may be documented in the Anthem database. This database includes a secured system restricting access to only those with authorized entry. Computers are protected by a password known only to the computer user assigned to that computer. Computers with any computer screen displaying member or provider information shall not be left on and unattended.

- Electronic, facsimile or written clinical information received is secured, with limited access to employees to facilitate appropriate member care and reimbursement for such care. No confidential information or documents are left unattended (in other words, open carts, bins or trays at any time). Hard copies of all documents are not visible at any workstation during the employee's breaks, lunch or time spent away from desks.
- Written clinical information is stamped "Confidential," with a warning that its release is subject to California and federal law.
- Confidential information is stored in a secure area with access limited to specified employees, and medical information is disposed of in a manner that maintains confidentiality (in other words, paper shredding and destroying of recycle bin materials).
- Any confidential information used in reporting to other departments or to conduct training activities, which may include unauthorized staff, will be "sanitized" (in other words, all identifying information blacked out), to prevent the disclosure of confidential medical information.
- Any records related to quality of care, unexpected incidence investigations or other peer review matters are privileged communications. As such, these records are maintained as confidential. All such written information is stamped "Confidential" with a warning that its release is subject to state and federal law. Information is maintained in locked files.

Member Consent

Member authorization is not required for treatment, payment and health care operations. Direct treatment relationships (in other words, the provision and/or coordination of health care by providers) require member consent.

Member Access to Medical Records

Members may access their medical records upon request. For reviewed and approved requests to the Anthem compliance office, the member may provide a written amendment to their records if they believe that the records are incomplete or inaccurate.

No written request is required for information/documents for which a member would normally have access, such as copies of claims. Anthem validates the identity of the individual member (in other words, subscriber number, date of service, etc.) before releasing any information.

A written request signed by a member or the member's authorized representative is required to release medical records. An initial "consent to treat" may be signed at the point of entry into services prior to the provision of those services, but does not allow records to be released for any reasons other than those delineated in that original consent (in other words, payment and specialty referral authorization processes).

Anthem will assist the member who has difficulty obtaining requested medical records.

Release of Confidential Information

Members Considered Incompetent or Lacking the Legal Capacity to Give Consent to Medical Treatment

Incompetent members include:

- A member/conservatee who has been declared incompetent to consent to treatment by a court.
- A member/conservatee who has not been declared incompetent to consent to treatment, but whom the treating physician determines lacks the capacity to consent.
- A member who is not capable of understanding the nature and effect of the proposed treatment.

Anthem will consult with legal counsel, as appropriate. The durable power of attorney or letters of conservatorship may need to be reviewed by legal counsel to determine who may consent to the release of the member's information.

Release to Providers

Provider requests may be honored if the request pertains to that provider's services. All other requests require the member's or member representative's signed release for the information.

Electronic, facsimile or written clinical information sent is secured with limited access to those employees who are facilitating appropriate patient care and reimbursement for such care.

Release of Outpatient Psychotherapy Records

Anyone requesting member outpatient psychotherapy records must submit a written request, except when the patient has signed a written letter or form waiving notification to the member and treating provider. The request must be sent to the member within 30 days of the receipt of the records except when the member has signed a written letter or form waiving notification. The written request must be signed by the requestor and must identify:

- What information is requested
- The purpose of the request and
- The length of time the information will be kept

A person or entity may extend the timeframe, provided that the person or entity notifies the practitioner of the extension. Any notification of the extension will include:

- The specific reason for the extension
- The intended use or uses of the information during the extended time
- The expected date of the destruction of the information

The request will include a statement that:

- The information will not be used for any purpose other than its intended use
- That the requestor will destroy the information when it is no longer needed (including how the documents will be destroyed)

The request must specifically include the following:

- Statement that the information will not be used for any purpose other than its intended use

- Statement that the person or entity requesting the information will destroy the information when it is no longer needed
- Specifics on how the information will be destroyed, or specify that the person or entity will return the information and all copies of it before or immediately after the length of time indicated in the request
- Specific criteria and process for confidentially faxing and copying outpatient psychotherapy records

Release of Records Pursuant to a Subpoena
Member information will only be released in compliance with a *subpoena duces tecum* received by Anthem as follows:

- The subpoena is to be accepted, dated and timed by the above person or designee.
- The subpoena should give Anthem at least 20 days from the date the subpoena is issued to allow a reasonable time for the member to object to the subpoena and/or preparation and travel to the designated stated location.
- All subpoenas must be accompanied by either a written authorization for the release of medical records or a "proof of service" demonstrating the member has been "served" with a copy of the subpoena.
- Alcohol or substance abuse records are protected by both federal and state law (42 CFR § 2.1 *et seq*.) and may not be released unless there is also a court order for release which complies with the specific requirements.
- Only the requested information will be submitted (HIV and AIDS information is excluded; this requires a specific subpoena). Should a notice contesting the subpoena be received prior to the required date, records will not be released without a court order requiring so. If no notice is received, records will be released at the end of the 20-day period.

The record will be sent through the U.S. Postal Service by registered receipt or certified mail.

Archived Files/Medical Records
All medical records are retained by Anthem and/or the delegated/contracted medical groups, as well as individual practitioner offices, according to the following criteria:

- Adult patient charts – 10 years
- X-rays – 10 years

CareMore Health
CareMore Health has the responsibility to coordinate care for our Anthem Blue Cross Cal MediConnect Plan population in Los Angeles County and Santa Clara Counties. As an Anthem Blue Cross affiliate, CareMore will work with you and the Anthem Blue Cross Cal MediConnect Plan membership. CareMore will reach out to you to coordinate your patient's care. This does not change your contractual relationship with Anthem Blue Cross Cal MediConnect Plan. Providers contracted with CareMore Health can access additional resources at **https://www.caremore.com/Providers/Current-Provider.aspx**.

CHAPTER 2: CONTACTS

Overview

Quick Reference Information	
Anthem Blue Cross Cal MediConnect Plan Customer Care	Contact Anthem Blue Cross Cal MediConnect Plan at **855-878-1785** or Los Angeles: **888-350-3447** for Member Eligibility, 24/7 NurseLine and Pharmacy services. Los Angeles Pharmacy member services: **833-214-3606** Santa Clara Pharmacy member services: **833-370-7466** Helpdesk: **833-377-4266**
CareMore	**888-291-1358**
Member Services	Telephone: **1-855-817-5785 (TTY 711)**
Medical Notification/ Precertification	• May be telephoned, submitted online or faxed to Anthem: ○ Telephone: **855-878-1785** (Anthem Blue Cross Cal MediConnect Plan) ○ **888-291-1358** (CareMore) ○ Fax: **562-977-6141** ○ Web: **https://mediproviders.anthem.com/ca** • Data required for complete notification/precertification: ○ Member ID number ○ Legible name of referring provider ○ Legible name of individual referred to provider ○ Number of visits/services requested ○ Dates of service ○ Diagnosis ○ CPT code or other code for services to be provided • Clinical staff is available during normal business hours from 8 a.m. to 6 p.m. Pacific time. • Clinical information supporting need for services is required for precertification; the Precertification Request form is also available online.
Claims Submission: Paper	Submit paper claims to: Anthem Blue Cross Cal MediConnect Plan P.O. Box 60007 Los Angeles, CA 90060-0007
Claims Submission: Electronic Data Interchange (EDI)	Electronic filing methods are preferred for accuracy, convenience, and speed. Electronic Data Interchange (EDI) allows providers to submit and receive electronic transactions from their computer systems. For more information on EDI, call Availity* Client Services at **800-AVAILITY** (**800-282-4548**). Availity Client Services is available Monday - Friday 8 a.m. - 8 p.m. ET.

<table>
<tr><th colspan="2">Quick Reference Information</th></tr>
<tr><td></td><td>The following sender/payer IDs should be used when filing electronic claims/transactions through Anthem. Payer ID assignment for claims submitted through a clearinghouse or a software vendor should be verified with the vendor to ensure the correct value is assigned to the claim transaction. Many clearing agencies use proprietary payer IDs; therefore, we do not assign or maintain payer ID codes for other entities, clearinghouses or vendors.

<table>
<tr><th>Professional</th><th>Institutional</th><th>Dental</th></tr>
<tr><td>47198</td><td>47198</td><td>84103</td></tr>
</table>
Providers can access the list of Availity provider payer IDs here.</td></tr>
<tr><td>National Provider Identifier</td><td>National Provider Identifier (NPI) —HIPAA requires the adoption of a standard unique provider identifier for health care providers. All Anthem participating providers must have an NPI number.

Note: Atypical providers do not require an NPI number. An atypical provider is an individual or business that is not a health care provider and does not meet the definition of a health care provider according to the NPI rules.

The NPI is a 10-digit intelligence-free numeric identifier. Intelligence-free means the numbers do not carry information about health care providers, such as the state in which they practice or their specialty.

Providers can apply for an NPI by completing an application:
• Online at https://nppes.cms.hhs.gov (Estimated time to complete the NPI application is 20 minutes)
• By downloading a paper copy at https://nppes.cms.hhs.gov
• By calling 800-465-3203 and requesting an application

Please send your NPI to:
Provider Data Management
Anthem Blue Cross
P. O. Box 27401
Richmond, VA 23279-7401
Email: NPImail@anthem.com</td></tr>
<tr><td>Payment Disputes</td><td>If you believe Anthem has not paid for your services according to the terms of your Provider Agreement or wish to dispute a timely filing denial or submit a second request of a claim reconsideration, submit a request using the Provider Dispute Resolution Request form located online under Forms at https://mediproviders.anthem.com/ca.</td></tr>
</table>

Quick Reference Information	
	Submit provider payment disputes to: Provider Payment Disputes Anthem Blue Cross P.O. Box 61599 Virginia Beach, VA 23466
Member Liability Appeals	For appeals initiated by a member or by a provider on the member's behalf when the denial of authorization or payment assigns member liability, please refer to the denial letter or EOP issued to determine the correct appeals process to follow. All member liability appeals should be sent to: Complaints, Appeals and Grievances Department Anthem Blue Cross Mailstop: OH0205-A4537 4361 Irwin Simpson Rd Mason, OH 45040 Phone: **888-350-3447 – Santa Clara** **855-817-5785 – Los Angeles** Fax: **888-458-1406** A member or a provider acting on behalf of a member may appeal the decision to deny, terminate, suspend or reduce services. In the event that the member or physician believes that waiting the standard appeal time frame would endanger the member's life, health or ability to regain maximum functioning, an expedited or fast appeal can be initiated. Please clearly indicate if you are requesting an expedited appeal.
Nonemergent Transportation	**American Logistics*** Reservations: **844-923-0704** Monday through Friday from 8 a.m. to 8 p.m. Pacific time Ride Assistance (Where's My Ride): **844-923-0704** 24 hours daily (TTY: **711**)
Provider Appeals	The provider appeal process is used to address the request for reconsideration of the denial of payment for a service. The denial reasons include inappropriate site of service, lack of medical necessity, no prior authorization and noncovered services. Provider appeals must be submitted in writing. Any supporting documentation should accompany the appeal request and be forwarded to: Complaints, Appeals and Grievances Department Anthem Blue Cross Mailstop: OH0205-A537 4361 Irwin Simpson Rd

Quick Reference Information	
	Mason, OH 45040 Fax: **888-458-1406** **888-326-1479 – Santa Clara**
Provider Service Representatives	For more information, contact Anthem Blue Cross Cal MediConnect Plan Customer Care at **888-291-1358**
Translation/ Interpreter Services	For assistance with translation services for your patients, please contact Anthem Blue Cross Cal MediConnect Plan Customer Care at 888-350-3447, Santa Clara and **855-817-5786, Los Angeles**.
Vision Services	**VSP***: **800-615-1883** Monday through Friday from 5 a.m. to 8 p.m. Pacific time Saturday 7 a.m. to 8 p.m. Pacific time Sunday 7 a.m. to 7 p.m. Pacific time (TTY: **800-428-4833**) Website: **www.vsp.com**
Pharmacy Prior Authorization	Contact Anthem Blue Cross Cal MediConnect Plan Customer Care at **833-293-0661** or via fax at **844-493-9213**

CHAPTER 3: PARTICIPATING PROVIDER INFORMATION

Enrollment and Eligibility Verification

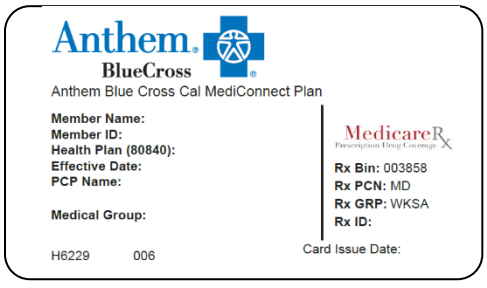
All health care providers are responsible for verifying enrollment and eligibility before services are rendered, except in the case of an emergency. In general, eligibility should be verified at the time of service and at least once monthly for ongoing services. In an emergency, eligibility should be determined as soon as possible after the member's condition is stabilized. When a patient presents as a member, providers must verify eligibility, enrollment and coverage by performing the following steps:

- Request the member's Anthem Blue Cross Cal MediConnect Plan card; if there are questions regarding the information, call Anthem Blue Cross Cal MediConnect Plan Customer Care at **888-350-3447 for Santa Clara County and 855-817-5785 for Los Angeles County** to verify eligibility, deductibles, coinsurance amounts, copays and other benefit information, or use the online Provider Inquiry Tool at **https://mediproviders.anthem.com/ca**.
- Copy both sides of the member's Anthem Blue Cross Cal MediConnect Plan card and place the copies in the member's medical record.
- Copy the member's driver's license (if applicable) to ensure the member's information matches their Anthem Blue Cross Cal MediConnect Plan card and place the copies in the member's medical record.
- If you are a PCP, check your Anthem Blue Cross Cal MediConnect Plan member panel listing to ensure you are the member's doctor.
- If the patient does not have an identification card, use the online Provider Inquiry Tool at **https://mediproviders.anthem.com/ca** or call Anthem Blue Cross Cal MediConnect Plan Customer Care at **888-291-1358**

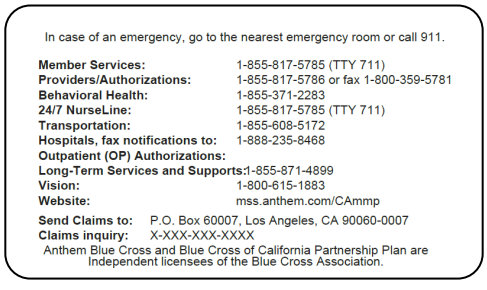
Identification Card for the Anthem Blue Cross Cal MediConnect Plan

The member will have a single ID card for the Anthem Blue Cross Cal MediConnect Plan:

Front of card



Back of card



Noncompliant Anthem Blue Cross Cal MediConnect Plan Members

Anthem recognizes providers may need help in managing nonadherent members. If you have an issue with a member regarding behavior, treatment cooperation, completion of treatment and/or making or appearing for appointments, call Provider Services at Anthem Blue Cross Cal MediConnect Plan Customer Care at **888-291-1358**. A Member Services or Provider Services

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

Access and Availability

Participating Anthem Blue Cross Cal MediConnect Plan providers must:

- Offer hours of operation that are no less than the hours of operations offered to their other patients (for example, commercial or public fee for service insured).
- Provide coverage for members 24 hours a day, 7 days a week.
- Ensure another on-call Anthem Blue Cross Cal MediConnect Plan provider is available to administer care when the PCP is not available.
- Not substitute hospital emergency rooms or urgent care centers for covering providers.
- See members within 30 minutes of a scheduled appointment, or inform them of the reason for delay (for example, emergency cases) and offer an alternative appointment.
- Provide an after-hours telephone service to ensure a response to emergency phone calls within 30 minutes and a response to urgent phone calls within one hour; individuals who believe they have an emergency medical condition should be directed to immediately seek emergency services from the nearest emergency facility.

Access and Availability Standards Table

Type of Appointment: Medical (See Behavioral Health Chapter 6 for specific Behavioral Health Access Standards)	**Availability Standard**
Nonurgent primary care appointments	Within 10 business days of request
Urgent care appointments for services that do not require prior authorization	Within 48 hours of request
Urgent appointment for services that do require prior authorization	Within 96 hours of request
Appointment with a specialist	Within 15 business days of request
Nonurgent appointment for ancillary services for diagnosis or treatment of illness or other health condition	Within 15 business days of request
Prenatal visit	Within 14 calendar days of request

Anthem monitors adherence to appointment availability standards through office visits, long-term care visits, and tracking of complaints and grievances related to access and/or discrimination. Deviations from the policy are reviewed by the Medical Director for educational and/or counseling opportunities and tracked for provider recredentialing.

All providers and hospitals are expected to treat Anthem Blue Cross Cal MediConnect Plan members with the same dignity and consideration as afforded to their non-Coordinated Care patients.

Plan-specific Termination Criteria

The occurrence of any of the following is grounds for termination of the Anthem provider's participation:

- Loss of reputation among peers due to unethical clinical practice or attitude
- The practice of fraud, waste and/or abuse
- Adverse publicity involving the provider due to acts of omission or commission
- Substance abuse
- Loss of professional office
- Inadequate record keeping
- Unsafe environment in the provider's office relative to inadequate access or other related issues that might cause member injury
- An office that is improperly kept or unclean, or does not present a proper appearance
- Failure to meet OSHA guidelines
- Failure to meet ADA guidelines
- Failure to meet Clinical Laboratory Improvement Amendments (CLIA) guidelines
- Customer satisfaction ratings that drop below pre-established standards as determined by the Medical Advisory Committee (MAC) (this would include complaints relative to appearance, behavior, medical care, etc.)
- Repetitive complaints about office staff demeanor, presentation and appearance
- Inclusion on the Debarred Providers Listing of the Office of the Inspector General of the Department of Health and Human Services (see "Sanctioned Providers" section below)
- Unfavorable inpatient- or outpatient-related indicators:
    - Severity-adjusted morbidity and mortality rates above established norms
    - Severity-adjusted length-of-stay above established norms
    - Unfavorable outpatient utilization results
    - Consistent inappropriate referrals to specialists
    - Improper maintenance of high-risk patients, such as those members with diabetes and hypertension
    - Underutilization relative to minimum standards of care established per medical management guidelines and/or accepted clinical practice in the community
    - Unfavorable malpractice-related issues
    - Frequent litigious activity above and beyond what would be expected for a Provider in that particular specialty

Anthem providers have 30 calendar days to appeal a termination. The Anthem process is designed to comply with all state and federal regulations regarding the termination appeal process.

Laws Regarding Federal Funds

Payments providers receive for furnishing services to members are derived in whole or part from federal funds. Therefore, providers and any approved subcontractors must comply with certain laws applicable to individuals and entities receiving federal funds, including but not limited to Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 84, the Age Discrimination Act of 1975 as implemented by 45 CFR Part 91, the Rehabilitation Act of 1973 and the Americans with Disabilities Act.

Prohibition Against Discrimination

Neither Anthem nor its contracted providers may deny, limit or condition the coverage or furnishing of services to members on the basis of any factor related to health status, including but not limited to the following:

- Medical condition, including mental as well as physical illness
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence
- Disability

Reporting Obligations

Cooperation in Meeting CMS Requirements

Anthem is required to provide information to CMS necessary to administer and evaluate the Anthem Blue Cross Cal MediConnect Plan and to establish and facilitate a process for current and prospective members to exercise their choice in obtaining services.

Anthem provides the following information:

- Plan quality and performance indicators such as HEDIS outcomes and disenrollment rates (for beneficiaries enrolled in the plan the previous two years Information on member satisfaction
- Information on health outcomes

Providers must cooperate with Anthem in its data reporting obligations by providing Anthem with any information required to meet these obligations in a timely fashion.

Certification of Diagnostic Data

Anthem is required to submit information to CMS necessary to characterize the context and purposes of each encounter between a member and provider, supplier, physician or other practitioner (encounter data). Providers that furnish diagnostic data must certify (to the best of their knowledge, information and belief) the accuracy, completeness and truthfulness of the data.

Cultural Competency

Cultural competency is the integration of congruent behaviors, attitudes, structures, policies and procedures that come together in a system or agency or among professionals. Cultural competency assists providers and members to:

- Acknowledge the importance of culture and language
- Assess cross-cultural relations
- Embrace cultural strengths with people and communities
- Strive to expand cultural knowledge
- Understand cultural and linguistic differences

Cultural Competence

Understanding those values, beliefs and needs associated with the member's age, gender identity, sexual orientation, and/or racial, ethnic or religious background. Cultural competence also includes a set of competencies which are required to ensure appropriate, culturally sensitive health care to persons with congenital or acquired disabilities. A competency based on the premise of respect for member and cultural differences and an implementation of a trust-promoting method of inquiry and assistance.

The quality of the patient-provider interaction has a profound impact on the ability of a patient to communicate symptoms to his or her provider and to adhere to recommended treatment. Some reasons a provider needs to be culturally competent include but are not limited to:

- The perception that illness and disease and their causes vary by culture
- The diversity of belief systems related to health, healing and wellness are very diverse
- The fact that culture influences help-seeking behaviors and attitudes toward health care providers
- The fact that individual preferences affect traditional and nontraditional approaches to health care
- The fact that patients must overcome their personal biases within health care systems
- The fact that health care providers from culturally and linguistically diverse groups are under-represented in the current service delivery system

Cultural barriers between the provider and member can impact the patient-provider relationship in many ways, including but not limited to:

- The member's level of comfort with the practitioner and the member's fear of what might be found upon examination
- The differences in understanding amongst the diverse consumers in the U.S. health care system
- A fear of rejection of personal health beliefs
- The member's expectation of the health care provider and of the treatment

To be culturally competent, Anthem expects providers serving members within their geographic locations to demonstrate the following:

Cultural Awareness

- The ability to recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior
- The ability to modify one's own behavioral style to respond to the needs of others, while at the same time maintaining one's objectivity and identity

Cultural Knowledge

- Culture plays a crucial role in the formation of health or illness beliefs
- Culture is generally behind a person's rejection or acceptance of medical advice and treatment
- Different cultures have different attitudes about seeking help
- Feelings about disclosure are culturally unique
- There are differences in the acceptability and effectiveness of treatment modalities in various cultural and ethnic groups
- Verbal and nonverbal language, speech patterns and communication styles vary by culture and ethnic groups
- Resources such as formally trained interpreters should be offered to and used by members with various cultural and ethnic differences

Cultural Skills

- The ability to understand the basic similarities and differences between and among the cultures of the persons served
- The ability to recognize the values and strengths of different cultures
- The ability to interpret diverse cultural and nonverbal behavior
- The ability to develop perceptions and understanding of other's needs, values and preferred means of having those needs met
- The ability to identify and integrate the critical cultural elements of a situation to make culturally consistent inferences and to demonstrate consistency in actions
- The ability to recognize the importance of time and the use of group processes to develop and enhance cross-cultural knowledge and understanding
- The ability to withhold judgment, action or speech in the absence of information about a person's culture
- The ability to listen with respect
- The ability to formulate culturally competent treatment plans
- The ability to use culturally appropriate community resources
- The ability to know when and how to use interpreters and to understand the limitations of using interpreters
- The ability to treat each person uniquely
- The ability to recognize racial and ethnic differences and know when to respond to culturally based cues
- The ability to seek out information
- The ability to use agency resources
- The capacity to respond flexibly to a range of possible solutions

- The acceptance of ethnic differences among people and the understanding of how these differences affect the treatment process
- The willingness to work with clients of various ethnic minority groups

For more information on cultural competency, please visit our provider website at **https://mediproviders.anthem.com/ca.**

Marketing

Providers may not develop or use any materials that market the Anthem Blue Cross Cal MediConnect Plan without Anthem's prior written approval. Under program rules, an organization may not distribute any marketing materials or make such materials or forms available to individuals eligible to elect a Cal MediConnect plan unless the materials meet the CMS marketing guidelines and are first submitted to CMS for review and approval. Additionally, providers can have plan marketing materials in their office as long as marketing materials for all plans the providers participate in are represented. Providers are allowed to have posters or notifications that show they participate in the Anthem Blue Cross Cal MediConnect Plan as long as the provider displays posters or notifications from all plans in which they participate.

Americans with Disabilities Act (ADA) Requirements

Anthem policies and procedures are designed to promote compliance with the ADA. Providers are required to take 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 the following:

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

For more information, please access the ADA website at **www.ada.gov**.

CHAPTER 4: HEALTH CARE BENEFITS

Member Eligibility

In order to participate in the Anthem Blue Cross Cal MediConnect Plan, a member must meet the following criteria:

- Age 21 and older at the time of enrollment
- Entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits
- Reside in a demonstration area

Individuals who meet at least one of the exclusion criteria listed below shall be excluded from the demonstration as appropriate:

- Individuals under age 21
- Individuals who are required to "spend down" income in order to meet Medicaid eligibility requirements, not including members in long-term care/skilled nursing facilities (SNFs)
- Individuals for whom DHCS only pays a limited amount each month toward their cost of care (for example, deductibles), including non-full benefit Medicaid beneficiaries such as:
    - Qualified Medicare beneficiaries (QMBs)
    - Special low income Medicare beneficiaries (SLMBs)
    - Qualified disabled working individuals (QDWIs)
    - Qualifying individuals (QIs)

The following individuals may receive Medicaid coverage for the following: Medicare monthly premiums for Part A, Part B or both (carved-out payment), coinsurance, copay and deductible for Medicare-allowed services and Medicaid-covered services, including those that are not covered by Medicare:

- Individuals who are residents of state hospitals, ICF/MR facilities, residential treatment facilities or long-stay hospitals. Note that dual eligible individuals residing in nursing facilities will be enrolled in the demonstration. For more information on eligibility, please visit **www.calduals.org.**
- Individuals receiving the end stage renal disease (ESRD) Medicare benefit at the time of enrollment into the demonstration. However, an individual who develops ESRD while enrolled in the demonstration will remain in the demonstration, unless he/she opts out. If he/she opts out, the individual cannot opt back into the demonstration.
- Individuals with other comprehensive group or individual health insurance coverage other than full benefit Medicare; insurance provided to military dependents; and any other insurance purchased through the Health Insurance Premium Payment program (HIPP).
- Individuals who have a Medicaid eligibility period that is less than three months.
- Individuals who have a Medicaid eligibility period that is only retroactive.
- Individuals enrolled in the Money Follows the Person (MFP) program.

- Individuals residing outside of the demonstration areas.
- Individuals enrolled in a Program of All-Inclusive Care for the Elderly (PACE). However, PACE participants may enroll in the demonstration if they choose to disenroll from their PACE provider.
- Individuals participating in the CMS Independence at Home (IAH) demonstration. However, IAH participants may enroll in the demonstration if they choose to disenroll from IAH.

Role of the Enrollment Broker

To support enrollment decisions, the California Department of Health Care Services (DHCS) will ensure that enrollees are educated on benefits and Anthem networks, the process for opting out of the demonstration and for changing their managed care organization (MCO) membership. DHCS will focus on developing clear and accessible information (ensuring availability in alternative formats and languages) on available MCOs and consumer protections. To help facilitate enrollment choices, DHCS will contract with a neutral enrollment broker to:

- Help educate enrollees
- Assist with enrollment and MCO selection
- Operate a toll-free enrollee helpline

Summary of the Benefits Tables

Notations regarding some benefit categories are listed below. Please note availability and limitations. Please refer to the appropriate Summary of Benefits listed below for detailed information.

Precertification requirements are described in later sections and in detail on the provider website. All services from noncontracted providers with the exceptions of urgent and emergent care and out-of-area dialysis require precertification.

The medical benefits are further explained in the following sections.

Covered Services	
Abdominal aortic aneurysm screening	• Coverage – includes one ultrasound screening for people at risk.* Members must obtain a referral during “Welcome to Medicare” preventive visit. **This screening is covered only if the member has certain risk factors and gets a referral from their physician, physician assistant, nurse practitioner, or clinical nurse specialist.*
Acupuncture	Covered for up to two outpatient acupuncture services in any one calendar month, or more often if they are medically necessary.

Covered Services	
Alcohol misuse screening and counseling	• Coverage includes one alcohol-misuse screening (SBIRT) for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women. • Members who screen positive for alcohol misuse can get up to four brief, face-to-face counseling sessions each year with a qualified PCP or practitioner in a primary care setting.
Ambulance services	Covered ambulance services include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take the member to the nearest place to provide care. Member condition must be serious enough that other ways of getting to a place of care could risk the member's life or health. Ambulance services for other cases must be approved by Anthem. In cases that are *not* emergencies, Anthem may pay for an ambulance. The member's condition must be serious enough that other ways of getting to a place of care could risk member's life or health.
Annual wellness visit	Members can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. Anthem will pay for this once every 12 months.
Behavioral health services	Members have access to medically necessary behavioral health services that are covered by Medicare and Medi-Cal. The Anthem Blue Cross Cal MediConnect Plan provides access to behavioral health services covered by Medicare. Medi-Cal covered behavioral health services are not provided by the Cal MediConnect Plan, but will be available to eligible members through Santa Clara County Behavioral Health Services Department.

Covered Services	
Bone mass measurement	Coverage includes certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. Anthem will pay for the services once every 24 months or more often if they are medically necessary. Anthem will also pay for a provider to look at and comment on the results.
Breast cancer screening (mammograms)	Coverage includes the following services: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months
Cardiac (heart) rehabilitation services	Coverage includes cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor's referral. Coverage also includes intensive cardiac rehabilitation programs.
Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)	Coverage includes one visit a year with a PCP to help lower the member's risk for heart disease. During this visit, providers may: • Discuss aspirin use, • Check blood pressure, and/or • Provide information to make sure members are eating well.
Cardiovascular (heart) disease testing	Coverage includes blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.

Covered Services	
Cervical and vaginal cancer screening	Coverage includes: • For all women: Pap tests and pelvic exams once every 24 months • For women who are at high risk of cervical cancer: one Pap test every 12 months • For women who have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months
Chiropractic services	Coverage includes the following services: • Adjustments of the spine to correct alignment.
Colorectal cancer screening	Coverage for members 50 and older includes the following services: • Flexible sigmoidoscopy (or screening barium enema) every 48 months • Fecal occult blood test every 12 months For members at high risk of colorectal cancer, Anthem will pay for one screening colonoscopy (or screening barium enema) every 24 months. For people not at high risk of colorectal cancer, Anthem will pay for one screening colonoscopy every 10 years (but not within 48 months of a screening sigmoidoscopy).
Community Based Adult Services (CBAS)	CBAS is an outpatient, facility-based service program where people attend according to a schedule. It delivers skilled nursing care, social services, therapies (including occupational, physical, and speech), personal care, family/caregiver training and support, nutrition services, transportation, and other services. Anthem will cover CBAS if you meet the eligibility criteria. **Note: If a CBAS facility is not available, Anthem can provide these services separately.**

Covered Services	
Counseling to stop smoking or tobacco use	If a member uses tobacco but does not have signs or symptoms of tobacco-related disease: • Anthem will cover two counseling quit attempts in a 12-month period as a preventive service. This service is free for the member. Each counseling attempt includes up to four face-to-face visits. If a member uses tobacco and has been diagnosed with a tobacco-related disease, or is taking medicine that may be affected by tobacco: • Anthem will cover two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. If a member is pregnant, they may receive unlimited tobacco cessation counseling with prior authorization.
Dental services	Benefits including dentures are provided by the state's Denti-Cal program effective **May 1, 2014**. These services are not provided through Anthem. For more information, members may call Denti-Cal at **800-322-6384**. TTY users should call **800-735-2922**.
Depression screening	Coverage includes one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals.
Diabetes screening	Coverage includes screening (including fasting glucose tests) if the member has any of the following risk factors: • High blood pressure (hypertension) • History of abnormal cholesterol and triglyceride levels (dyslipidemia) • Obesity • History of high blood sugar (glucose) Tests may be covered in some other cases such as if the member is overweight and has a family history of diabetes. Depending on the test results, members may qualify for up to two diabetes screenings every 12 months.

Covered Services	

Diabetic self-management training, services, and supplies	Coverage includes the following services for all members who have diabetes (whether they use insulin or not):
	• Supplies to monitor blood glucose, including the following:
	  ○ A blood glucose monitor
	  ○ Blood glucose test strips
	  ○ Lancet devices and lancets
	  ○ Glucose-control solutions for checking the accuracy of test strips and monitors
	• Members with diabetes who have severe diabetic foot disease, Anthem covers the following:
	  ○ One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, or
	  ○ One pair of depth shoes and three pairs of inserts each year (not including the noncustomized removable inserts provided with such shoes).
	  ○ Coverage also includes fitting the therapeutic custom-molded shoes or depth shoes.
	• Training to help members manage their diabetes, in some cases.

Durable medical equipment and related supplies	The following items are covered: • Wheelchairs • Crutches • Hospital beds • Nebulizers • Oxygen equipment • IV infusion pumps • Walkers Other items **may** be covered.

Covered Services	

Emergency care	Emergency care means services that are:
	• Given by a provider trained to give emergency services, **and**
	• Needed to treat a medical emergency.
	A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:
	• Placing the person's health in serious risk; **or**
	• Serious harm to bodily functions; **or**
	• Serious dysfunction of any bodily organ or part; **or**
	• In the case of a pregnant woman, an active labor, meaning labor at a time when either of the following would occur:
	  ○ There is not enough time to safely transfer the member to another hospital before delivery.
	  ○ The transfer may pose a threat to the health or safety of the member or unborn child.
	Emergency care is not covered outside the U.S. and its territories except under limited circumstances. Contact us for details.

Covered Services	
Family planning services	Members may choose any provider for certain family planning services. Coverage includes the following services: • Family planning exam and medical treatment • Family planning lab and diagnostic tests • Family planning methods (birth control pills, patch, ring, IUD, injections, implants) • Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) • Counseling and diagnosis of infertility, and related services • Counseling and testing for sexually transmitted infections (STIs), AIDS and other HIV-related conditions • Treatment for sexually transmitted infections (STIs) • Voluntary sterilization (Members must be age 21 or older and must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.) • Genetic counseling Coverage also includes some other family planning services, however the members must see a provider in our provider network for the following services: • Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.) • Treatment for AIDS and other HIV-related conditions • Genetic testing
Health and wellness education programs	Coverage includes programs that focus on certain health conditions. These include: • Health education classes; • Nutrition education classes; • Smoking and tobacco use cessation; and • 24/7 NurseLine

Covered Services	
Hearing services	Coverage includes hearing and balance tests. They are covered as outpatient care when a member gets them from a physician, audiologist or other qualified provider. Hearing aid allowance of $1510 for both ears combined per fiscal year (July 1-June 30) and includes sales tax, molds, modification supplies and accessories. The allowance cap does not apply if you are pregnant or residing in a nursing facility. • Molds, supplies and inserts • Repairs that cost more than $25 per repair • An initial set of batteries • Visits for training, adjustments and fitting with the same vendor after the member gets the hearing aid • Trial period rental of hearing aids Supplemental hearing benefits are limited to: • One routine hearing exam every calendar year
HIV screening	Coverage includes one HIV screening exam every 12 months for members who: • Ask for an HIV screening test, **or** • Are at increased risk for HIV infection. For women who are pregnant, coverage includes up to three HIV screening tests during a pregnancy.
Home-delivered meals	Covers up to 7 days of hot nutritious meals delivered to the home. Qualified members must be: homebound, at-risk, recently discharged from the hospital, unable to prepare food and not have anyone who can help prepare food in the home.
Home health agency care	Coverage includes the following services, and maybe other services not listed here: • Physical therapy, occupational therapy and speech therapy • Medical and social services • Medical equipment and supplies

Covered Services	
Hospice care	Coverage is available from any hospice program certified by Medicare. The hospice provider can be a network provider or an out-of-network provider. Coverage includes the following: • Drugs to treat symptoms and pain • Short-term respite care • Home care **For hospice services and services covered by Medicare Part A or B that relate to a member's terminal illness:** • The hospice provider will bill Medicare for services. Medicare will pay for hospice services and any Medicare Part A or B services. **For services covered by Medicare Part A or B that are not related to terminal illness** (except for emergency care or urgently needed care): • The provider will bill Medicare for services. Medicare will pay for the services covered by Medicare Part A or B. **For services covered by Anthem Blue Cross Cal MediConnect Plan but not covered by Medicare Part A or B:** • Anthem will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to terminal illness. Any Medi-Cal eligible member certified by a physician as having a life expectancy of six months or less may elect to receive hospice care in lieu of normal Medi-Cal coverage for services related to the terminal condition. Covered hospice services include routine home care, continuous home care, respite care, general inpatient care, and specialty physician services.

Covered Services	
Hospice care (continued)	**Coverage includes two 90-day periods, followed by an unlimited number of 60-day periods. Any covered services provided after the member's election of the hospice benefit becomes the financial responsibility of the hospice.** *For drugs that may be covered by Anthem Blue Cross Cal MediConnect Plan's Medicare Part D benefit:* If a member needs nonhospice care, the member should contact their case manager to arrange the services. Nonhospice care is care that is not related to your terminal illness.
Immunizations	Coverage includes the following services: • Pneumonia vaccine • Flu shots, once a year, in the fall or winter • Hepatitis B vaccine if the member is at high or intermediate risk of getting hepatitis B • Other vaccines if the member is at risk and they meet Medicare Part B coverage rules Coverage also includes other vaccines that meet the Medicare Part D coverage rules.

Covered Services	
In-Home Supportive Services (IHSS)	Coverage is provided so that the member can remain safely in their own home. The types of IHSS which can be authorized through the County Department of Social Services are: • Housecleaning • Meal preparation • Laundry • Grocery shopping • Personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services) • Accompaniment to medical appointments • Protective supervision for the mentally impaired To qualify for IHSS, a member must be aged, blind, or disabled and, in most cases, have income below the level to qualify for the Supplemental Security Income/State Supplementary program. If eligible, you may receive up to 283 hours of IHSS every month if approved by your county social worker.
Inpatient hospital care	Coverage includes the following services, and maybe other services not listed here: • Semi-private room (or a private room if it is medically necessary) • Meals, including special diets • Regular nursing services • Costs of special care units, such as intensive care or coronary care units • Drugs and medications • Lab tests • X-rays and other radiology services • Needed surgical and medical supplies • Appliances, such as wheelchairs • Operating and recovery room services • Physical, occupational and speech therapy • Inpatient substance abuse services • In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell and intestinal/multivisceral

Covered Services	
Inpatient hospital care (continued)	If a member needs a transplant, a Medicare-approved transplant center will review the case and decide whether the member is a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then the member can get their transplant services locally or at a distant location outside the service area. If Anthem provides transplant services at a distant location outside the service area and the member chooses to get their transplant there, Anthem will arrange or pay for lodging and travel costs for the member and one other person. • Blood, including storage and administration • Physician services
Inpatient mental health care	Coverage includes mental health care services that require a hospital stay. • Coverage includes inpatient services in a freestanding psychiatric hospital for the first 190 days. After that, the local county mental health agency will pay for inpatient psychiatric services that are medically necessary. Authorization for care beyond the 190 days will be coordinated with the local county mental health agency. • The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. • For members 65 years or older, Anthem will cover services received in an institute for mental diseases (IMD).

Covered Services	

Inpatient services covered during a noncovered inpatient stay	Inpatient stays that are not reasonable and needed will be denied.
	In some cases, coverage for services obtained while the member is admitted in the hospital or a nursing facility will be covered. Coverage includes the following services, and maybe other services not listed here:
	• Doctor services
	• Diagnostic tests, like lab tests
	• X-ray, radium and isotope therapy, including technician materials and services
	• Surgical dressings
	• Splints, casts and other devices used for fractures and dislocations
	• Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that:
	  ○ Replace all or part of an internal body organ (including contiguous tissue), or
	  ○ Replace all or part of the function of an inoperative or malfunctioning internal body organ.
	• Leg, arm, back, and neck braces, trusses and artificial legs, arms and eyes. This includes adjustments, repairs and replacements needed because of breakage, wear, loss or a change in the patient's condition
	• Physical therapy, speech therapy and occupational therapy

Covered Services	
Kidney disease services and supplies	Coverage includes the following services: • Kidney disease education services to teach kidney care and help members make good decisions about their care. Members must have stage IV chronic kidney disease and be referred by their physician. Coverage includes up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area. • Inpatient dialysis treatments if the member is admitted as an inpatient to a hospital for special care • Self-dialysis training, including training for the member and anyone helping the member with home dialysis treatments • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on home dialysis, to help in emergencies, and to check dialysis equipment and water supply.
Medical nutrition therapy	Coverage for members with diabetes or kidney disease without dialysis; also for after a kidney transplant, when referred by a member's doctor. Coverage includes: • Three hours of one-on-one counseling services during the first year that the member receives medical nutrition therapy services under Medicare. (This includes our plan or Medicare.) • Up to 10 hours of initial outpatient diabetes self-management training in a continuous 12-month period, with up to two hours of follow-up training each subsequent calendar year following the completion of the full 10 hours of initial training. • Training may be done in any combination of half hour increments. A physician must prescribe these services and renew the referral each year if treatment is needed in the next calendar year.

Covered Services	
Medicare Part B prescription drugs	These drugs are covered under Medicare Part B. Anthem will pay for the following drugs: • Injected or infused while provided by a physician, hospital outpatient, or ambulatory surgery center services • Drugs taken using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors – self-injection for members with hemophilia • Immunosuppressive drugs, if a member is enrolled in Medicare Part A at the time of the organ transplant • Osteoporosis drugs that are injected; these drugs are paid for if the member is homebound, has a bone fracture that a doctor certifies was related to post-menopausal osteoporosis and cannot inject the drug themselves • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically needed), topical anesthetics and erythropoiesis-stimulating agents (such as Procrit® and Aranesp®) • IV immune globulin for the home treatment of primary immune deficiency diseases

Covered Services	
Multi-Purpose Senior Services Program (MSSP)	MSSP is a case management program that provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals. To be eligible, a member must be 65 years of age or older, live within a site's service area, be able to be served within MSSP's cost limitations, be appropriate for care management services, currently eligible for Medi-Cal, and certified or certifiable for placement in a nursing facility. MSSP services include: • Adult Day Care/Support Center • Housing assistance • Chore and personal care assistance • Protective supervision • Care management • Respite • Transportation • Meal services • Social services • Communications services This benefit is covered up to $4,285 per year.
Nonemergency medical transportation	This benefit allows for transportation that is the most cost-effective and accessible. This can include: ambulance, litter van, wheelchair van, medical transportation services and coordinating with para transit. The forms of transportation are authorized when: • Medical and/or physical condition does not allow the member to travel by bus, passenger car, taxicab or another form of public or private transportation • Transportation is required for the purpose of obtaining needed medical care. Depending on the service, prior authorization may be required.

Covered Services	
Nonmedical transportation	This benefit allows for transportation to medical services by passenger car, taxi, or other forms of public/private transportation. Members will have access to 30 one-way trips per year. This benefit does not limit your nonemergency medical transportation benefit.
Nursing facility care	A nursing facility (NF) is a place that provides care for members who cannot get care at home but who do not need to be in a hospital. Coverage includes, but is not limited to, the following: • Semiprivate room (or a private room if it is medically needed) • Meals, including special diets • Nursing services • Physical therapy, occupational therapy and speech therapy • Drugs given to the member as part of their plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.) • Blood, including storage and administration • Medical and surgical supplies usually given by nursing facilities • Lab tests usually given by nursing facilities • X-rays and other radiology services usually given by nursing facilities • Use of appliances, such as wheelchairs usually given by nursing facilities • Physician/practitioner services • Durable medical equipment • Dental services, including dentures • Vision benefits • Hearing exams • Chiropractic care • Podiatry services

Covered Services	
Nursing facility care (continued)	Members will usually get care from network facilities. However, members may be able to get care from a facility not in our network. Members can get care from the following places if they accept Anthem's amounts for payment: • A nursing home or continuing care retirement community where the member was living right before being admitted to the hospital (as long as it provides nursing facility care). • A nursing facility where a member's spouse is living at the time the members is discharged from the hospital.
Obesity screening and therapy to keep weight down	Coverage available for members with a body mass index of 30 or more includes counseling to help the member lose weight. Member must get the counseling in a primary care setting and be managed within the member's full prevention plan.
Out-of-area dialysis services	Members may obtain medically necessary dialysis services from any qualified provider when they are temporarily absent from the Anthem Blue Cross Cal MediConnect Plan service area and cannot reasonably access contracted Anthem Blue Cross Cal MediConnect Plan dialysis providers. Members can obtain dialysis services without precertification or notification when outside of the Anthem Blue Cross Cal MediConnect Plan service area. We suggest members advise Anthem if they will temporarily be out of the service area so that a qualified dialysis provider may be recommended.

Covered Services	
Outpatient diagnostic tests and therapeutic services and supplies	Coverage includes the following services, and maybe other services not listed here: • X-rays • Radiation (radium and isotope) therapy, including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used for fractures and dislocations • Lab tests • Blood, including storage and administration • Other outpatient diagnostic tests
Outpatient hospital services	Coverage available for medically needed services available in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Coverage includes the following services, and maybe other services not listed here: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Labs and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it • X-rays and other radiology services billed by the hospital • Medical supplies, such as splints and casts • Some screenings and preventive services • Some drugs that you cannot be self-administered

Covered Services	
Outpatient mental health care	Coverage includes mental health services provided by: • A state-licensed psychiatrist or doctor • A clinical psychologist • A clinical social worker • A clinical nurse specialist • A nurse practitioner • A physician assistant • Any other Medicare-qualified mental health care professional as allowed under applicable state laws Coverage includes the following services, and maybe other services not listed here: • Clinic services • Day treatment • Psychosocial rehab services • Partial hospitalization/intensive outpatient programs • Individual and group mental health evaluation and treatment • Psychological testing when clinically indicated to evaluate a mental health outcome • Outpatient services for the purposes of monitoring drug therapy • Outpatient laboratory, drugs, supplies and supplements • Psychiatric consultation
Outpatient rehabilitation services	Coverage includes physical therapy, occupational therapy and speech therapy. Members can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs) and other facilities.

Covered Services	
Outpatient substance abuse services	Coverage for the following services, and maybe other services not listed here: • Alcohol misuse screening and counseling • Treatment of drug abuse • Group or individual counseling by a qualified clinician • Subacute detoxification in a residential addiction program • Alcohol and/or drug services in an intensive outpatient treatment center • Extended release Naltrexone (Vivitrol) treatment
Outpatient surgery	Coverage available for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.
Partial hospitalization services	Partial hospitalization is a structured program of active psychiatric treatment. It is offered in a hospital outpatient setting or by a community mental health center. It is more intense than the care a member gets in their doctor's or therapist's office. It can help keep members from having to stay in the hospital. **Note**: Because there are no community mental health centers in our network, we cover partial hospitalization only in a hospital outpatient setting.

Covered Services	

Physician/provider services, including doctor's office visits	Coverage includes the following services:
	• Medically necessary health care or surgery services given in places such as:
	  ○ Physician's office
	  ○ Certified ambulatory surgical center
	  ○ Hospital outpatient department
	• Consultation, diagnosis, and treatment by a specialist
	• Basic hearing and balance exams given by a primary care provider **or** specialist
	• Some telehealth services, including consultation, diagnosis and treatment by a physician or practitioner for members in rural areas or other places approved by Medicare. Preauthorization required.
	• Second opinion before a medical procedure
	• Nonroutine dental care. Covered services are limited to:
	  ○ Surgery of the jaw or related structures
	  ○ Setting fractures of the jaw or facial bones
	  ○ Pulling teeth before radiation treatments of neoplastic cancer
	  ○ Services that would be covered when provided by a physician

Podiatry services	Coverage includes the following services: • Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • Routine foot care for members with conditions affecting the legs, such as diabetes

Covered Services	
Prescription Drug Coverage	Santa Clara Anthem Blue Cross Cal MediConnect Plan follows the following formulary tier structure: Tier 1 – Medicare Part D preferred generic and brand name drugs with $0 copay Tier 2 – Medicare Part D non-preferred and preferred generic and brand name drugs with $0-$9.20 copay Tier 3 – MediCal state approved prescription generic and brand name drugs with $0 copay Tier 4 – Medi-Cal approved over-the-counter (OTC) drugs that require a prescription $0 copay Los Angeles Anthem Blue Cross Cal MediConnect Plan follows the following formulary tier structure: Tier 1 – Medicare Part D preferred generic and brand name drugs with $0 copay Tier 2 – Medicare Part D non-preferred and preferred generic and brand name drugs with $0 copay Tier 3 – MediCal state approved prescription generic and brand name drugs with $0 copay Tier 4 – Medi-Cal approved over-the-counter (OTC) drugs that require a prescription $0 copay

Covered Services	
Prescription Drugs	Prescription drugs are only available by prescription, are used or sold in the United States and must be used for medically accepted indications. Prescription drugs covered by Anthem Blue Cross Cal MediConnect Plan are listed in the Anthem Blue Cross Cal MediConnect Plan formulary. The formulary includes all generic drugs covered under the program, as well as many brand-name drugs, nonpreferred brands and specialty drugs. You can view a copy of the formulary on the Anthem website at **https://mediproviders.anthem.com/ca** or request a copy from the Provider Relations department. Some of these drugs have precertification or step-therapy requirements or quantity limits. Providers may request authorization for a drug or coverage of a drug not on the formulary by contacting the Pharmacy department at **833-370-7466** Members should obtain covered drugs from a network pharmacy pursuant to a physician's prescription. Pharmacy claims are processed by IngenioRx*, the Anthem Blue Cross Cal MediConnect Plan pharmacy benefit management vendor. IngenioRx services also include home infusion, LTC pharmacy and mail-order pharmacy. More information on these services can be obtained by contacting the Pharmacy department at the number listed above.

Covered Services	
Prescription Drugs by Mail Order	Members can use the mail-order service to fill prescriptions for maintenance drugs (in other words, drugs taken on a regular basis for a chronic or long-term medical condition). For mail-order prescriptions, the physician must write on the maintenance drug prescription whether it is for a 31-, 62- or 93-day supply. When mailing in a prescription to the mail-order service for the first time, the member should allow up to two weeks for the prescription to be filled. For refills of the same prescription, members should allow up to two weeks for mailing and processing. If a member runs out of a medication before receiving a new supply from the mail-order pharmacy, please call the IngenioRx home delivery number at **833-203-1738**. They will assist with obtaining an emergency supply of the member's medication until he or she receives the new mail-order supply. Members are not required to use mail-order prescription drug services to obtain an extended supply of maintenance medications. Members also have the option of using a retail pharmacy in the network to obtain their maintenance medications. Some retail pharmacies may agree to accept the mail-order reimbursement rate for an extended supply of medication, which may result in no out-of-pocket payment difference to the member.

Covered Services	

Preventative services	The following preventive services are offered to members with no member copay or cost sharing:
	• Preventive visit
	  ○ Annual physical examination (in addition to the Medicare preventive visits)
	  ▪ You may bill for one routine annual visit per year (for example, 99385–99387, 99395–99397) with diagnosis code V70.0
	  ○ Welcome to Medicare exam
	  ○ Annual wellness exam
	• Bone mass measurements
	• Colorectal screening
	• Diabetic monitoring training
	• Cardiovascular disease testing
	• Mammography screening
	• Pap smear, pelvic exams and clinical breast exams
	• Prostate cancer screening exams
	• Abdominal aortic aneurysm screening
	• Diabetes screening
	• EKG screening
	• Flu shots
	• Glaucoma tests
	• Hepatitis B shots
	• HIV screenings
	• Medical nutrition therapy services
	• Pneumococcal shots
	• Smoking cessation (counseling to stop smoking)
	• Depression screening

Prostate cancer screening exams	Coverage for men age 50 and older, includes the following services once every 12 months: • A digital rectal exam • A prostate specific antigen (PSA) test

Covered Services	
Prosthetic devices and related supplies	Coverage includes the following prosthetic devices, and maybe other devices not listed here: • Colostomy bags and supplies related to colostomy care • Pacemakers • Braces • Prosthetic shoes • Artificial arms and legs • Breast prostheses (including a surgical brassiere after a mastectomy) • Incontinence cream and diapers Coverage also includes some supplies related to prosthetic devices, including repair or replacement of prosthetic devices. **Exclusions: Prosthetic dental devices**
Pulmonary rehabilitation services	Coverage includes pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). Members must have a referral **or** an order for pulmonary rehabilitation from the doctor or provider treating the COPD. Coverage also includes respiratory services for ventilator-dependent patients.
Sexually transmitted infections (STIs) screening and counseling	Coverage includes screenings for chlamydia, gonorrhea, syphilis and hepatitis B. These screenings are covered for pregnant members and for some members who are at increased risk for an STI. A PCP must order the tests. Coverage is limited to once every 12 months, or at certain times during pregnancy.

Covered Services	
Skilled nursing facility care	Coverage includes the following services, and maybe other services not listed here: • A semi-private room, or a private room if it is medically needed • Meals, including special diets • Nursing services • Physical therapy, occupational therapy and speech therapy • Drugs the member gets as part of their plan of care, including substances that are naturally in the body, such as blood-clotting factors • Blood, including storage and administration • Medical and surgical supplies given by nursing facilities • Lab tests given by nursing facilities • X-rays and other radiology services given by nursing facilities • Appliances, such as wheelchairs, usually given by nursing facilities • Physician/provider service Members will usually get care from network facilities. However, members may be able to get care from a facility not in our network. Members can get care from the following places if they accept our plan's amounts for payment: • A nursing home or continuing care retirement community where a member lived before they went to the hospital (as long as it provides nursing facility care) • A nursing facility where the member's spouse lives at the time the member leaves the hospital

Covered Services	
Supplemental benefits	Supplemental benefits are those benefits in addition to the basic Medicare services offered through Medicare Part A and B and the California Medi-Cal program. Anthem offers limited supplemental benefits to covered members as outlined in the Summary of Benefits documents. Please refer to the Summary of Benefits for specific supplemental benefits being offered. Below is a list of supplemental benefits Anthem offers. Please refer to the Summary of Benefits documents for details on which plans cover certain supplemental benefits. • Routine foot and nail care; up to four visits per year • Supplemental routine eye examinations once yearly • Up to $200 every two years for eyeglasses or contact lenses • Routine hearing examinations and hearing aids • Telephonic physician consultation services available through the 24/7 NurseLine, 24 hours a day, seven days a week Although not normally covered under the Medicare program, the following items are covered under the Medicaid component of the Anthem Blue Cross Cal MediConnect Plan: • Generic drugs covered in the Part D coverage gap with the applicable generic prescription • Nonemergency transportation Details on provider billing for rendered services are available on the Anthem provider website or by calling Anthem Blue Cross Cal MediConnect Plan Customer Care at **855-817-5786**.

Covered Services	
Urgent care	Urgent care is care given to treat **either**: • A nonemergency • A sudden medical illness • An injury • A condition that needs care right away. Members requiring urgent care should first try to get it from a network provider. However, members can use out-of-network providers when they cannot get to a network provider. Only emergency services are covered outside the U.S.
Vision care	Anthem Blue Cross Cal MediConnect Plan members will receive routine vision services through VSP. Members will have vision benefits which include annual routine eye exams and glasses. Coverage includes the following services: • One routine eye exam every year; and • Up to $200 for eyeglasses (frames and lenses) or up to $200 for contact lenses every two years. Coverage also includes outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. This includes treatment for age-related macular degeneration. For members at high risk of glaucoma, coverage includes one glaucoma screening each year. Members at high risk of glaucoma include: • Members with a family history of glaucoma • Members with diabetes • African-Americans who are age 50 and older Coverage includes one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. Coverage also includes corrective lenses, frames and replacements if a member needs them after a cataract removal without a lens implant.

Covered Services	
"Welcome to Medicare" Preventive Visit	Coverage includes the one-time "Welcome to Medicare" preventive visit. The visit includes: • A review of the members health, • Education and counseling about the preventive services a member needs (including screenings and shots), and • Referrals for other care if needed **Important**: Anthem covers the "Welcome to Medicare" preventive visit only during the first 12 months that a member has Medicare Part B.

Pharmacy – Formulary Exceptions

If a prescription drug is not listed in the Anthem Blue Cross Cal MediConnect Plan formulary, please check the updated formulary on the Anthem website. The website formulary is updated frequently with any changes. In addition, providers may contact the Anthem Blue Cross Cal MediConnect Plan Pharmacy department to be sure a drug is covered. If the Pharmacy department confirms the drug is not on the formulary, there are two options:

- The prescribing physician can prescribe another drug that is covered on the formulary.
- The patient or prescribing physician may ask Anthem to make an exception (a type of coverage determination) to cover the nonformulary drug. If the member pays out-of-pocket for a nonformulary drug and requests an exception Anthem approves, Anthem will reimburse the member. If the exception is not approved, the member may appeal the plan's denial. See the "Member Liability Appeals" section for more information on requesting exceptions and appeals.

In some cases, Anthem will contact a member who is taking a drug that is not on the formulary. Anthem will give the member the names of covered drugs used to treat his or her condition and encourage the member to ask his or her physician if any of those drugs would be appropriate options for treatment. Also, members who recently joined the Anthem Blue Cross Cal MediConnect Plan may be able to get a temporary supply of a drug they are taking if the drug is not on the Anthem Blue Cross Cal MediConnect Plan formulary.

Pharmacy – Transition Policy

New members may be taking drugs that are not on the formulary or that are subject to certain restrictions, such as precertification or step-therapy. Current members may also be affected by changes in the formulary from one year to the next. Members are encouraged to talk to their providers to decide if they should switch to a different drug Anthem covers, or request a formulary exception in order to get coverage for the drug (as described above).

During the period of time members are talking to their providers to determine the right course of action, Anthem may provide a temporary supply of the nonformulary drug if those members need a refill for the drug during the first 90 days of new membership in the Anthem Blue Cross Cal MediConnect Plan. For current members affected by a formulary change from one year to the next, Anthem will provide a temporary supply of the nonformulary drug for members needing a refill for the drug during the first 90 days of the new plan year.

When a member goes to a network pharmacy and Anthem provides a temporary supply of a drug that is not on the formulary or that has coverage restrictions or limits, Anthem will cover at least a one-time, 31-day supply (unless the prescription is written for fewer days). After we cover the temporary 31-day supply, Anthem generally will not pay for these drugs again as part of the transition policy. Anthem provides the member with a written notice after it covers a temporary supply. The notice will explain the steps the member can take to request an exception, and the way to work with the prescribing physician to decide if switching to an appropriate formulary drug is feasible.

If a member is new to the plan and lives in a long-term care facility, we will cover a temporary supply of the member's drug **during the first 90 days of their membership** in the plan. The total supply will be for a maximum of a 34day supply, depending on the dispensing increment. If the member's prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 34-day supply of medication.

If the member has been enrolled in the plan for more than 90 days and needs a drug that is not on the formulary or is subject to other restrictions such as step therapy or dosage limits, Anthem will cover a temporary 31-day emergency supply of that drug (unless the prescription is for fewer days) while the new member requests a formulary exception.

This policy also applies to current members who experience a change in the level of their care. For example, if a member leaves the hospital and enters a long-term care facility, or leaves hospice status and reverts back to standard care, the member may receive a temporary transition supply of the nonformulary drug for up to 31 days, unless the prescription is written for fewer days.

CHAPTER 4:
LONG TERM SERVICES AND SUPPORTS (LTSS)

Overview

Anthem covers a wide variety of long-term services and supports (LTSS) that help elderly individuals and/or individuals with disabilities with their daily needs, and improve the quality of their lives.

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

- In home supportive services (IHSS)
- Community-based adult services (CBAS)
- Multipurpose Senior Services program (MSSP)
- Long-term services and supports/skilled nursing facility

In-Home Supportive Services (IHSS)

This state program provides in-home care to the elderly and persons with disabilities allowing them to safely remain in their homes.

Eligibility

To qualify for IHSS, an enrollee must be aged, blind or disabled and in most cases, have income below the level to qualify for SSI/State Supplementary program.

All IHSS beneficiaries must:

- Be a California resident and a U.S. citizen/legal resident, and be living in their own home
- Be eligible to receive supplemental security income/state supplemental payment (SSI/SSP) or Medi-Cal benefits
- Be 65 years of age or older, legally blind or disabled by Social Security standards
- Submit a Health Care Certification form (SOC 873) from a licensed health care professional, indicating that they need assistance to stay living at home.

County Public Authority

The County Public Authority social worker is responsible for assessing, approving and authorizing hours, services and tasks based on the needs of the beneficiary. They are responsible for screening and enrolling service providers, conducting criminal background checks, conducting provider orientation and retaining enrollment documentation. In addition, they maintain a provider registry and can provide assistance in finding eligible providers, and perform quality assurance activities.

Types of services provided include:

- Domestic and related services (for example, house cleaning/chores, meal preparation and clean-up, laundry, grocery shopping and heavy cleaning)

- Personal care (in other words, bathing, grooming, dressing and feeding)
- Paramedical services (in other words, administration of medication, puncturing skin and range of motion exercises)
- Other services (in other words, accompaniment to medical appointments, yard hazard abatement and protective supervision)

IHSS Referral – How a beneficiary or provider accesses IHSS
The county department of Social Services Agency determines eligibility and hours of service. The beneficiary can apply to IHSS by calling **408-792-1600 (Santa Clara county) 888-944-4477 (Los Angeles).**

The IHSS Public Authority assists beneficiaries with finding homecare workers, and providers other support services for IHSS beneficiaries. They can be reached at **408-350-3251 (Santa Clara county) 888-944-4477 (Los Angeles).**

IHSS Member Control/Responsibility

IHSS allows the member to self-direct their care by being able to hire, fire and manage their homecare workers. A trusted friend or family member could become screened, qualified and compensated as a member's IHSS Provider/Caregiver. The member could also elect to involve the IHSS Provider/Caregiver as a member of their Care Team.

County agencies administering the IHSS program will maintain their current roles and Anthem will not be able to reduce the IHSS hours authorized by the county. If a member or provider needs assistance they can contact their Anthem Service Coordinator..

Community Based Adult Services (CBAS)

CBAS is a facility-based outpatient program serving individuals 18 years and over, who have functional impairment that puts them at risk for institutional care. The program delivers the following adult day care services:

- Skilled nursing
- Social services
- Physical and occupational therapies
- Personal care
- Family/caregiver training and support
- Meals
- Transportation

The primary objectives of the CBAS program are to: restore and maintain optimal capacity for self-care to the elderly or other adults with physical and mental disabilities, and delay or prevent inappropriate or personally undesirable institutionalization in long-term care facilities.

Eligibility
CBAS services may be provided to Medi-Cal beneficiaries over 18 years of age 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

Anthem conducts an assessment to determine final program eligibility. CBAS centers still determine levels of service after authorization. Those currently enrolled in the CBAS program will remain in the program as long as they are enrolled in a Medi-Cal health plan. CBAS providers continue to follow the already established policies and procedures.

Referral
To receive CBAS services, a beneficiary must first be enrolled in a Medi-Cal health plan. To begin the referral process please contact Anthem's Member Services department at **855-871-4899** to begin the process. CBAS providers must obtain an authorization from Anthem.

Multipurpose Senior Services Program

The Multipurpose Senior Services Program (MSSP) is the California 1915c Home and Community Based Services (HCBS) waiver program that operates as an alternative to nursing home placement for those 65 years of age and over with disabilities. The MSSP is an intensive case management program that coordinates social and health care services in the community for those wishing to remain in the community and delay or prevent institutional placement.

Types of services provided:
- Case management
- Personal care services
- Respite care (in-home and out-of-home)
- Environmental accessibility adaptations
- Housing assistance/minor home repair
- Transportation
- Chore services
- Personal emergency response system (PERS)/Communication device
- Adult day care/support center/health care
- Protective supervision
- Meal services (congregate/home delivered)
- Social reassurance/therapeutic counseling
- Money management
- Translation/interpretation

MSSPs work closely with local organizations and agencies that provide LTSS and HCBS.

MSSP Referral
in order to receive MSSP services a beneficiary must first be enrolled in a Medi-Cal health plan like Anthem. To begin the referral process for a beneficiary, please contact our Care

Coordinators for assistance or our Member Services department. Contact numbers can be found in the "Contact" section of this manual.

MSSP Waiver Services
An MSSP provider may purchase MSSP Waiver Services when necessary to support the well-being of an Anthem member who is an MSSP Waiver participant.

Prior to purchasing these services, MSSP providers must verify and document all efforts to determine the availability of alternative resources (for example, family, friends and other community resources) for the member.

Approved Purchased Waiver Services are listed and defined in the MSSP Provider Site Manual located on the California Department of Aging website at **www.aging.ca.gov**. To access the MSSP manual on this site, select Providers and Partners > Multipurpose Senior Services Program > MSSP Site Manual .

MSSP providers may enter into contract with subcontractors and vendors to provide Purchased Waiver Services or directly purchase items through the use of a purchase order. Anthem requires MSSP providers to maintain written subcontractor/vendor agreements for the following minimum array of Purchased Waiver Services:

- Adult day support center (ADSC) and adult day care (ADC)
- Housing assistance
- Supplemental personal care services
- Care management
- Respite care
- Transportation
- Meal services
- Protective services
- Special communications

MSSP subcontractors and vendors are bound by the following:

- All MSSP subcontractors and vendors must have the proper license, credentials, qualifications or experience to provide services to any Anthem member receiving MSSP services.
- All reimbursements must come from the MSSP provider with whom the subcontractor or vendor has a signed agreement.
- No MSSP subcontractor or vendor may seek any payment for MSSP services from any Anthem member or from Anthem itself.

MSSP providers are responsible for coordinating and tracking MSSP purchased Waiver Services for any Anthem member receiving MSSP services.

For information about how to receive payment for MSSP services, please see **Reimbursement to Multipurpose Senior Services Program Providers** at the end of this chapter.

A prior authorization is not required for MSSP services provided by approved MSSP waiver providers.

Transition and Discharge Planning

When long-term services and supports are necessary, Anthem works with the provider and member (or their designated representative) to plan the transition/discharge to an appropriate setting for extended services. These services can be delivered in a nonhospital facility such as:

- Nursing facilities and subacute care facilities (NF/SCF)
- Respite care – in home or out of home
- Home and Community Based Services (HCBS)
- Home health care program (in other words, home I.V. antibiotics)

When the member and family, together with the provider, identify medically necessary and appropriate services for the member, Anthem will assist in providing a timely and effective plan that meets the member's needs and goals.

Responsibilities of the LTSS Provider

- Nursing homes must retain a copy of the member's Anthem plan of care on file with the member's records.
- All facility-based providers and home health agencies must notify an Anthem case manager within 24 hours when a member dies, leaves the facility, moves to a new residence or moves outside the service area or state.
- LTSS providers can participate in the member's Interdisciplinary Care Team (ICT) dependent on the member's need and preference.

Interactive Voice Response Requirements of Providers

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

- 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.

Identifying and Verifying the Long-Term Care Member

Upon enrollment, we will send a welcome package to the member. This package includes an introductory letter, a member ID card and a Member Handbook. Each Anthem member will identify himself or herself prior to receiving services by presenting an Anthem ID card which includes a member number. You can check member eligibility online via the state using any of the following:

- Our 24/7 Automated Eligibility Voice System (AEVS) at **800-546-2387**
- **https://www.medi-cal.ca.gov/Eligibility/Login.asp**
- If you have questions regarding eligibility and or benefits, contact Anthem Blue Cross Cal MediConnect Plan Customer Care at **888-350-3447 for Santa Clara County and 855-817-5785 for Los Angeles County**

Nursing Home Eligibility

Anthem will review the member's eligibility and benefits to determine if a member qualifies for nursing facility placement. This review will include the initial Level of Care (LOC) (including custodial nursing home vs. skilled nursing facility conducted by the Anthem Authorization/Case Manager/Care Coordinator.

For members who reside in a nursing home, the care coordinator will complete the health risk assessment within 60 days of plan enrollment via a face-to-face meeting. During this process, the Care Coordinator will ensure to incorporate Minimum Data Set 2.0 (MDS 2.0) into the plan of care. For more information please refer to **www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS20MDSAllForms.pdf.**

Anthem Coordination

The Anthem coordination model promotes cross-functional collaboration in the development of member service strategies. Members identified as waiver members, high risk and/or with complex needs are enrolled into the service coordination program and are provided individualized services to support their behavioral, social, environmental, functional and health needs. Service Coordinators accomplish this by screening, assessing and developing targeted and tailored member interventions while working collaboratively with the member, practitioner, provider, caregiver and natural supports.

Since many Anthem members have complex needs that require services from multiple providers and systems, gaps may occur in the delivery system serving these members. These gaps can create barriers to members receiving optimal care. The Anthem service coordination model helps reduce these barriers by identifying the unmet needs of members and assisting them in finding solutions to those needs. This may involve coordination of care, assisting members in accessing community-based resources – or any of a broad range of interventions designed to improve the quality of life and functionality of members – and to make efficient use of available health care and community based resources.

The scope of the service coordination model includes but is not limited to:

- Annual assessments of characteristics and needs of member populations and relevant sub-populations
- Initial and ongoing assessment
- Problem-based, comprehensive service planning, to include measurable prioritized goals and interventions tailored to the complexity level of the member as determined by the initial and ongoing assessments.
- Coordination of care with PCPs and specialty providers
- Providing a service coordination approach that is "member-centric" with support, access and education along the continuum of care
- Establishing a plan that is personalized to meet a member's specific needs and identifies: prioritized goals, time frames for reevaluation, resources to be utilized

including the appropriate level of care, planning for continuity of care, and family participation
- Obtaining member/family/caregiver input and level of participation in the creation of a service plan that includes the development of self-management strategies to increase the likelihood of improved health outcomes that may result in improved quality of life.

Consumer Direction

Consumer direction is a process by which eligible home and community based services (HCBS) are delivered; it is not a service.

Consumer direction affords members the opportunity to have choice and control over how eligible HCBS are provided. The program also allows members to have choice and control over who provides the services and how much workers are paid for providing care — up to a specified maximum amount established by California's DHCS. Member participation in consumer direction of HCBS is voluntary. Members may elect to participate in or withdraw from consumer direction of HCBS at any time without affecting their enrollment.

Consumer direction is offered for members who, through the needs assessment/reassessment process are determined by Care Coordinators to need any service specified in DHCS rules and regulations as available for consumer direction. These services include, but are not limited to:
- Attendant/personal care
- In-home respite care

A service that is not specified in DHCS rules and regulations as available for consumer direction shall not be consumer-directed.

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

Contact numbers for IHSS DPSS and PASC are in the **Contacts** section of the manual.

Discharge Planning

Anthem assists with discharge planning, either to the community or through a transfer to another facility, if the member or responsible party so requests. If the member or responsible party requests a discharge to the community, the Care/Service Coordinator will:
- Collaborate with the skilled nursing facility (SNF) Social Worker to convene a planning conference with the SNF staff to identify all potential needs in the community
- Facilitate a home visit to the residence where the member intends to move to assess environment, durable medical equipment (DME) and other needs upon discharge

- Convene a discharge planning meeting with the member and family, using the data compiled through discussion with the SNF staff as well as the home visit, to identify member preferences and goals
- Involve and collaborate with community originations such as Community Developmental Disability Organizations (CDDOs), Centers for Independent Living (CILs) or Area Agencies on Aging (AAAs) to assist members as they transition to the community
- Finalize and initiate execution of the transition plan

Although our member-centric approach is driven by the member, the transition implementation is a joint effort between the SNF Social Worker and the Anthem Care Coordinator.

Medical and Nonmedical Absences

Members are allowed up to seven days per confinement for reservation of a bed when an SNF, SNF/MH, or ICF/MR beneficiary leaves a facility and is admitted to an acute care facility and conditions under the reserve day regulations are met. To ensure accurate payment, the SNF, SNF/MH, or ICF/MR must bill hospital leave days consecutively beginning with the date of admission.

Members are allowed up to 21 days per admission for reservation of a bed when an SNF/MH resident leaves a facility and is admitted to one of the state mental hospitals, a private psychiatric hospital or a psychiatric ward in an acute care hospital. To ensure accurate payment, the SNF/MH must bill psychiatric leave days consecutively, beginning with the date of admission.

If a beneficiary is not admitted to a hospital but goes to a hospital for observation purposes only, it is considered an approved nursing facility day and **not** a hospital or therapeutic reserve day.

In the event of a **nonmedical** absence from a SNF, providers will obtain an authorization with the status changes on the nursing home member and should bill the end hold/leave of absence revenue code and accommodation code. A maximum of 18 home-leave days for SNFs and 21 days for SNF/MHs are allowed per calendar year. Additional days require precertification. Nonmedical reserve days are restricted to 21 days per year for ICF/MR residents.

Providers will not be reimbursed for days a bed is held for a resident beyond the limits set forth above and will not reimburse for medical absences without precertification.
Please make sure to bill with the appropriate revenue codes within the 018x series. In addition, you would bill the appropriate accommodation code with a Value Code of 24 and billed as a cent(s). Example, if the accommodation code is 2, then you would bill the Value Code 24 with $0.02.

Long-Term Care Ethics and Quality Committee
The Long-Term Care Ethics and Quality Committee addresses quality-of-care issues, ethical issues and standards of care. The committee reports to the Quality Management Committee. The Anthem Quality Management program is a positive one. Our focus is on identification, improvement, education and support so providers understand and comply with standards that impact the quality of care provided to our members.

Claims and Reimbursement Procedures

Precertification Requirements
Precertification, sometimes referred to as prior authorization (PA), is required for all SNF and LTSS services for which Medicaid is the primary payer, including all levels of care, medical and nonmedical absences, hospice services rendered in a SNF and Reserve Days (leaves of absence). The hospice provider is responsible for providing notification to Anthem and is required to pay the SNF room and board charges.

The provider must submit precertification requests with all supporting documentation immediately upon identifying an SNF admission or at least 72 hours prior to the scheduled admission.

MSSPs that are receiving a per member per month (PMPM) for a member are not required to obtain an authorization.
In order to ensure appropriate discharge planning, providers must provide notice to Anthem via our precertification process when the following events occur:

- Admission to an acute care or behavioral health care facility
- Admission to hospice room and board services

For members that enter the facility as "Medicaid Pending," please request a precertification as soon as the state approves the Medicaid eligibility and the member's eligibility is reflected on the Anthem website.

The Anthem website and this Provider Manual list the services that require precertification and notification. Our provider website also houses evidence-based criteria we use to complete precertification and concurrent reviews.

Anthem will follow the criteria established by DHCS authorizing short-term or long-term SNF stays.

The certification request can be submitted by:

- Faxing the request to **844-285-1167**
- Calling Care Management at **888-831-2246 (option 2)**
- For members selecting hospice services, Anthem will pay the hospice for the room and board charges, and the hospice will pay the SNF in accordance with CMS methodology and at the current applicable Medicaid rate

Providers can obtain the status of a precertification request by visiting our provider website at **https://mediproviders.anthem.com/ca**.

Retroactive Adjustments
Anthem understands the unique requirements of nursing facilities to accept residents as Medicaid pending. As soon as the facility receives notice from the state of Medicaid 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. Please note that it may take the state 24 to 48 hours to transmit an updated eligibility to Anthem.

Crossover Claims Procedures
In most cases, when a resident has met the criteria for a Medicare qualified stay in a certified Medicare bed, the Medicare cost share will be relayed to Anthem via a crossover file. We will then process and adjudicate the crossover claim. No further action should be necessary by the provider. Should a crossover claim not be received by Anthem, a claim can be submitted by the provider with a copy of the EOP from the other carrier for processing.

Corrected Claims Procedures
A corrected claim code XX7 or a replacement claim code XX8 may be submitted within 60 calendar days of the original claim's EOP date. When submitting a corrected claim, ensure that the applicable claim code is indicated on the claim form. Also ensure that corrected claims contain all applicable dates of service and/or revenue codes for processing.

Accommodation Codes
Accommodation codes are needed to ensure the appropriate reimbursement based on the Medi-Cal rates established by the state for each facility. Please bill the appropriate accommodation code with a value code of 24 and billed as a cent(s). Example, if the accommodation code is 1, then you would bill the value code 24 with $0.01.

Accommodation codes are available on the Medi-Cal Website at **http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp.** Please access the manual for Long Term Care and refer to the "Accommodation Codes" section.

Reimbursement to Multipurpose Senior Services Program (MSSP) Providers

MSSP providers must submit a monthly invoice/report to Anthem no later than the fifth day of each month for all members for the reimbursement of the PMPM payment. The invoice/report shall be for each Anthem member enrolled in the MSSP as of the first day of the month for which the report is submitted. Anthem will pay the MSSP provider no later than thirty days after receipt of an undisputed claim. The report submitted must include the following:

- The name of the Anthem member receiving the MSSP services
- The member's client index number (CIN)
- The MSSP provider's ID number

- Other items as identified by both the health plan and the MSSP

Anthem pays MSSP providers a fixed monthly amount for each Anthem member receiving MSSP Waiver Services. This amount is equal to one-twelfth (1/12) of the annual amount budgeted per MSSP Waiver slot allotment in the MSSP Waiver. This amount is provided by the state to Anthem.

MSSP providers must accept the Anthem payment as payment in full and final satisfaction of the Anthem payment obligation for MSSP Waiver Services for each MSSP Waiver participant enrolled in Anthem.

MSSP providers may not submit separate claims to different plans for the same MSSP Waiver participant within the same invoice period.

MSSP providers must make timely payments to their subcontractors and/or vendors.
The MSSP would then submit an encounter claim to Anthem within 60 days from the date of services. The encounter claim would then be processed as zero payment to the MSSP.

Any questions can be directed to your LTSS Provider Relations representative. If you do not know your LTSS representative, email **LTSSProviders@anthem.com**.

CHAPTER 5: CREDENTIALING AND RECREDENTIALING

Credentialing Program Structure

The National Credentials Committee (NCC) is the authorized entity for the development and maintenance of National Credentialing Policy. Policies approved by NCC will govern credentialing of network practitioners and HDOs, including but not limited to scope, criteria, confidentiality, delegation and appeals. Policies established by the National Credentials Committee will be presented to Anthem's Credentials Committee for input, review and adoption.

The NCC establishes a local credentialing and peer review body known as the Credentials Committee. The Credentials Committee (CC) is authorized by the NCC to evaluate and determine eligibility for practitioners and health delivery organizations (HDOs) to participate in the credentialed networks and be listed in the provider directories.

Credentialing Program Scope

Anthem credentials the following health care practitioners:

- Medical doctors
- Doctors of osteopathic medicine
- Doctors of podiatry
- Chiropractors
- Optometrists providing health services covered under the health benefits plan
- Doctors of dentistry providing health services covered under the health benefits plan including oral maxillofacial surgeons
- Psychologists who are state certified or licensed and have doctoral or master's level training
- Clinical social workers who are state certified or state licensed and have master's level training
- Psychiatric nurse practitioners who are nationally or state certified or state licensed or behavioral nurse specialists with master's level training
- Other behavioral health care specialists who are licensed, certified or registered by the state to practice independently
- Telemedicine practitioners who have an independent relationship with Anthem and who provide treatment services under the health benefits plan
- Medical therapists (for example, physical therapists, speech therapists and occupational therapists)
- Licensed genetic counselors who are licensed by the state to practice independently
- Audiologists who are licensed by the state to practice independently
- Acupuncturists (non-medical doctors or doctors of osteopathic medicine) who are licensed, certified or registered by the state to practice independently
- Nurse practitioners who are licensed, certified or registered by the state to practice independently

- Certified nurse midwives who are licensed, certified or registered by the state to practice independently
- Physician assistants (as required locally)

Anthem also certifies the following behavioral health practitioners (including verification of licensure by the applicable state licensing board to independently provide behavioral health services):

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

Anthem credentials the following health delivery organizations (HDOs):

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Nursing homes
- Free-standing surgical centers
- Behavioral health facilities providing mental health and/or substance abuse treatment in an inpatient, residential or ambulatory setting, 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 abuse
  - Methadone maintenance clinics
  - Outpatient mental health clinics
  - Outpatient substance abuse clinics
  - Partial hospitalization – mental health and/or substance abuse
  - Residential treatment centers (RTC) – psychiatric and/or substance abuse
- Birthing centers
- Convenient care centers/retail health clinics
- Intermediate care facilities
- Urgent care centers
- Federally qualified health centers (FQHC)
- Home infusion therapy agencies
- Rural health clinics

Credentials Committee

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

The CC will meet at least once every 45 calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the vice president of medical and credentialing policy, will designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. The chair must be a state or regional lead medical director, or an Anthem medical director designee and the vice-chair must be a lead medical officer or an Anthem medical director designee for that line of business not represented by the chair. In states or regions where only one line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five, but no more than ten, external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics; obstetrics/gynecology; adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types of credentialed health providers (e.g. nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair's discretion. At least two of the physician committee members must be credentialed for each line of business (e.g. Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.
The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant's participation, or terminate a practitioner from participation in one or more networks or plan programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are network practitioners.

During the credentialing process, all information that is obtained is highly confidential. All CC meeting minutes and practitioner files are stored in locked cabinets and can only be seen by appropriate Credentialing staff, medical directors and CC members. Documents in these files may not be reproduced or distributed, except for confidential peer review and credentialing purposes; and peer review protected information will not be shared externally.

Practitioners and HDOs are notified that they have the right to review information submitted to support their credentialing applications. This right includes access to information obtained from any outside sources with the exception of references, recommendations or other peer review protected information. Providers are given written notification of these rights in communications from Anthem which initiates the credentialing process. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, the Credentialing staff will contact the practitioner or HDO within 30 calendar days of the identification of the issue. This communication will specifically notify the practitioner or HDO of the right to correct erroneous information or provide additional details

regarding the issue in question. This notification will also include the specific process for submission of this additional information, including where it should be sent. Depending on the nature of the issue in question, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue(s) in question, including copies of the correspondence or a detailed record of phone calls, will be clearly documented in the practitioner's credentials file. The practitioner or HDO will be given no less than fourteen (14) calendar days in which to provide additional information. Upon request, applicant will be provided with the status of his or her credentialing application.

Written notification of this right may be included in a variety of communications from Anthem which includes the letter which initiates the credentialing process, the provider web site or Provider Manual. When such requests are received, providers will be notified whether the credentialing application has been received, how far in the process it has progressed and a reasonable date for completion and notification. All such requests will be responded to verbally unless the provider requests a written response.

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

Nondiscrimination Policy

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

Initial Credentialing

Each practitioner or HDO must complete a standard application form when applying for initial participation in one or more of Anthem's networks or plan programs. This application may be a state mandated form or a standard form created by or deemed acceptable by Anthem. For practitioners, the Council for Affordable Quality Healthcare (CAQH), a Universal Credentialing Datasource is utilized. CAQH built the first national provider credentialing database system, which is designed to eliminate the duplicate collection and updating of provider information for

health plans, hospitals and practitioners. To learn more about CAQH, visit their website at **www.CAQH.org**.

Anthem will verify those elements related to an applicants' legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the one hundred eighty (180) calendar-day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

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

A. Practitioners

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

B. HDOs

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

Recredentialing

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

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

All applicable practitioners and HDOs in the network within the scope of Anthem Credentialing Program are required to be recredentialed every three (3) years unless otherwise required by contract or state regulations.

Health Delivery Organizations

New HDO applicants will submit a standardized application to Anthem for review. If the candidate meets Anthem screening criteria, the credentialing process will commence. 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 recredentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail in Anthem Credentialing Program Standards, 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.

Recredentialing of HDOs occur every three (3) years unless otherwise required by regulatory or accrediting bodies. Each HDO applying for continuing participation in networks or plan programs must submit all required supporting documentation.

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

Ongoing Sanction Monitoring

To support certain credentialing standards between the recredentialing cycles, Anthem has established an ongoing monitoring program. Credentialing performs ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department will review periodic listings/reports within thirty (30) calendar

days of the time they are made available from the various sources including, but not limited to, the following:

1. Office of the Inspector General (OIG)
2. Federal Medicare/Medicaid Reports
3. Office of Personnel Management (OPM)
4. State licensing boards/agencies
5. Covered individual/customer services departments
6. Clinical Quality Management Department (including data regarding complaints of both a clinical and nonclinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
7. Other internal Anthem departments
8. Any other verified information received from appropriate sources

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response including, but not limited to: review by the Chair of Anthem CC, review by the Anthem Medical Director, referral to the CC, or termination. Anthem credentialing departments will report practitioners or HDOs to the appropriate authorities as required by law.

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 participation in Anthem's networks for professional competence and conduct 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 the intent of Anthem 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 competence and conduct considerations. Immediate terminations may be imposed due to the practitioner's or HDO's suspension or loss of licensure, criminal conviction, or Anthem's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to covered individuals. A practitioner/HDO whose license has been suspended or revoked has no right to 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. Once Anthem receives a verification of the NPDB report, the

verification report will be sent to the state licensing board. The credentialing staff will comply with all state and federal regulations in regard to the reporting of adverse determinations relating to professional conduct and competence. These reports will be made to the appropriate, legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

Anthem Credentialing Program Standards

I. Eligibility Criteria

Health care practitioners:
Initial applicants must meet the following criteria in order to be considered for participation:

A. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP; and
B. Possess a current, valid, unencumbered, unrestricted and non-probationary license in the state(s) where he/she provides services to covered individuals; and
C. Possess a current, valid, and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat covered individuals; the DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating covered individuals. Practitioners who see covered individuals in more than one state must have a DEA/CDS registration for each state.

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

A. For MDs, DOs, DPMs and oral and maxillofacial surgeons, 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 Podiatric Surgery (ABPS), American Board of Podiatric Medicine (ABPM), or American Board of Oral and Maxillofacial Surgery (ABOMS)) in the clinical discipline for which they are applying. Individuals will be granted five years after completion of their residency program to meet this requirement.
    1. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
        a. Previous board certification (as defined by one of the following: ABMS, AOA, RCPSC, CFPC) 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. OR
        b. 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
        c. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their

specialty AND a faculty appointment of Assistant Professor or higher at an academic medical center and teaching Facility in Anthem's network AND the applicant's professional activities are spent at that institution at least 50% of the time.

2. Practitioners meeting one of these three alternative criteria (a, b, c) 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 delegate to Anthem must contain sufficient documentation to support the above alternatives, as determined by Anthem.

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

II. Criteria for Selecting Practitioners

A. New Applicants (Credentialing)

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations;
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 covered individuals;
6. No current license action;
7. No history of licensing board action in any state;
8. No current federal sanction and no history of federal sanctions (per System for Award Management (SAM), OIG and OPM report nor on NPDB report);
9. Possess a current, valid and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat covered individuals. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating covered individuals. Practitioners who treat covered individuals in more than one state must have a valid DEA/CDS registration for each applicable state.

Initial applicants who have NO DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he/she has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:

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

10. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions;
11. No history of or current use of illegal drugs or history of or current alcoholism;
12. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
13. No gap in work history greater than six months in the past five years with the exception of those gaps related to parental leave or immigration where 12-month gaps will be acceptable. Other gaps in work history of 6 to 24 months will be reviewed by the Chair of the CC and may be presented to the CC if the gap raises concerns of future substandard professional conduct and competence. In the absence of this concern the Chair of the CC may approve work history gaps of up to two years.

14. No history of criminal/felony convictions or a plea of no contest;
15. A minimum of the past 10 years of malpractice case history is reviewed.
16. 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;
17. No involuntary terminations from an HMO or PPO;
18. 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.

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

B. Currently Participating Applicants (Recredentialing)
    1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
    2. Re-credentialing application 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 re-credentialing application;

5. Currently participating providers 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 programs or provider network(s), 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 network(s) as well as Anthem's other credentialed provider network(s). Special consideration regarding the practitioner's continued participation in Anthem's other credentialed practitioner network(s) may be requested by the Vice President (VP) responsible for that network(s) if, in the opinion of the requesting VP, the following criteria are met: the federal sanction, debarment or exclusion is not reflective of significant issues of professional conduct and competence, and participation of the practitioner is important for network adequacy. The request with supporting information will be brought to Anthem's geographic Credentials Committee for consideration and final determination, without practitioner appeal rights related to the special consideration, regarding the practitioner's continued participation in Anthem's other credentialed provider network(s), if such participation would be permitted under applicable State regulation, rule or contract requirements.
6. Current, valid, unrestricted license to practice in each state in which the practitioner provides care to covered individuals;
7. *No current license probation;
8. *License is unencumbered;
9. No new history of licensing board reprimand since prior credentialing review;
10. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
11. Current DEA/CDS registration and/or state controlled substance certification without new (since prior credentialing review) history of or current restrictions;
12. 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 covered individuals needing hospitalization;
13. No new (since previous credentialing review) history of or current use of illegal drugs or alcoholism;
14. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
15. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
16. 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.

17. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
18. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
    a. Investment or business interest in ancillary services, equipment or supplies;
    b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    c. Voluntary surrender of state license related to relocation or nonuse of said license;
    d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    e. Nonrenewal of malpractice coverage or change in 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.
19. No QI data or other performance data including complaints above the set threshold.
20. Recredentialed 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 recredentialing.

C. Additional Participation Criteria and Exceptions for Behavioral Health Practitioners (Non Physician) Credentialing
    1. Licensed Clinical Social Workers (LCSW) or other master level social work license type:
        a. Master or doctoral degree in social work with emphasis in clinical social work from a program accredited by the Council on Social Work Education (CSWE) or the Canadian Association on Social Work Education (CASWE).
        b. Program must have been accredited within three years of the time the practitioner graduated.
        c. Full accreditation is required, candidacy programs will not be considered.
        d. If master's level degree does not meet criteria and practitioner obtained PhD training as a clinical psychologist, but is not licensed as such, the practitioner can

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

3. 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. Graduate school must be accredited from an institution accredited by one of the Regional Institutional Accrediting Bodies within three years of the time of the practitioner's graduation.
    b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
    c. Certification by the American Nurses Association (ANA) in psychiatric nursing. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner.
    d. Valid, current, unrestricted 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 covered individuals.
4. Clinical Psychologists:
    a. Valid state clinical psychologist license.
    b. Doctoral degree in clinical or counseling, psychology or other applicable field of study from an institution accredited by the APA within three years of the time of the practitioner's graduation.
    c. Education/Training considered as eligible for an exception is a practitioner whose doctoral degree is not from an APA accredited institution, but who is listed in the National Register of Health Service Providers in Psychology or is a Diplomat of the American Board of Professional Psychology.
    d. Master's level therapists in good standing in the network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the network and will not be subject to the above education criteria.
5. Clinical Neuropsychologist:
    a. Must meet all the criteria for a clinical psychologist listed in C.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 in Psychology with an area of expertise in neuropsychology may be considered.
    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, OR
ii. Documentation of applicable formal one year post-doctoral training (participation in CEU training alone would not be considered adequate), OR
iii. Letters from supervisors in clinical neuropsychology (including number of hours per week), OR
iv. Minimum of five years' experience practicing neuropsychology at least 10 hours per week.

6. Licensed Psychoanalysts:
   a. Applies only to Practitioners in states that license psychoanalysts.
   b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Credentialing Policy (e.g. psychiatrist, clinical psychologist, licensed clinical social worker).
   c. Practitioner must possess a valid psychoanalysis state license.
      i. Practitioner shall possess a master's or higher degree from a program accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, CACREP, or the COAMFTE listings. The institution must have been accredited within 3 years of the time the Practitioner graduates.
      ii. Completion of a program in psychoanalysis that is registered by the licensing state as licensure qualifying; or accredited by the American Board for Accreditation in Psychoanalysis (ABAP) or another acceptable accrediting agency; or determined by the licensing state to be the substantial equivalent of such a registered or accredited program.
         a) A program located outside the United States and its territories may be used to satisfy the psychoanalytic study requirement if the licensing state determines the following: it prepares individuals for the professional practice of psychoanalysis; and is recognized by the appropriate civil authorities of that jurisdiction; and can be appropriately verified; and is determined by the licensing state to be the substantial equivalent of an acceptable registered licensure qualifying or accredited program.
         b) Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
         c) Meet examination requirements for licensure as determined by the licensing state.

III. 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. Non-accredited HDOs are subject to individual review by the CC and will be considered for covered individual access need only when the CC review indicates compliance with Anthem standards and there are no deficiencies noted on the

Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are recredentialed at least every three years to assess the HDO's continued compliance with Anthem standards.

A. General Criteria for HDOs:
   1. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to covered individuals. 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 the Anthem's programs or provider network(s), 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 network(s) as well as the Anthem's other credentialed provider network(s). Special consideration regarding the HDO's continued participation in the Anthem's other credentialed practitioner network(s) may be requested by the Vice President (VP) responsible for that network(s) if, in the opinion of the requesting VP, the following criteria are met: the federal sanction, debarment or exclusion is not reflective of significant issues of professional conduct and competence, and participation of the HDO is important for network adequacy. The request with supporting information will be brought to the Anthem's geographic Credentials Committee for consideration and final determination, without HDO appeal rights related to the special consideration, regarding the HDO's continued participation in the Anthem's other credentialed provider network(s), if such participation would be permitted under applicable State regulation, rule or contract requirements.
   4. Liability insurance acceptable to Anthem.
   5. If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if Anthem's quality and certification criteria standards have been met.

B. Additional Participation Criteria for HDO by Provider Type:

HDO Type and Anthem Approved Accrediting Agent(s)

Medical Facilities Facility Type (Medical Care)	Acceptable Accrediting Agencies
Acute Care Hospital	CIQH, CTEAM, HFAP, DNV/NIAHO, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC
Birthing Center	AAAHC, CABC
Clinical Laboratories	CLIA, COLA
Convenient Care Centers (CCCs)/Retail Health Clinics (RHC)	DNV/NIAHO, UCAOA
Dialysis Center	TJC
Federally Qualified Health Center (FQHC)	AAAHC
Free-Standing Surgical Centers	AAAASF, AAPSF, HFAP, IMQ, TJC
Home Health Care Agencies (HHA)	ACHC, CHAP, CTEAM , DNV/NIAHO, TJC
Home Infusion Therapy (HIT)	ACHC, CHAP, CTEAM, HQAA, TJC
Hospice	ACHC, CHAP, TJC
Intermediate Care Facilities	CTEAM
Portable x-ray Suppliers	FDA Certification
Skilled Nursing Facilities/Nursing Homes	BOC INT'L, CARF, TJC
Rural Health Clinic (RHC)	AAAASF, CTEAM, TJC
Urgent Care Center (UCC)	AAAHC, IMQ, TJC, UCAOA

Rehabilitation

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

CHAPTER 6: PERFORMANCE AND TERMINATION

Provider Participation Decisions: Appeals Process

Upon a denial, suspension, termination or nonrenewal of a provider's participation in the provider network, Anthem acts as follows:

- The affected physician is given a written notice of the reasons for the action, including if relevant the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by Anthem
- The physician is allowed to appeal the action to a hearing panel
- The physician is provided written notice of the right to a hearing and the process and timing for requesting a hearing
- Anthem ensures the majority of the hearing panel members are peers of the affected physician
- Anthem notifies the National Practitioner Data Bank, the appropriate state licensing agency and any other applicable licensing or disciplinary body to the extent required by law, if a suspension or termination is the result of quality of care deficiencies
- Subcontracted physician groups must ensure these procedures apply equally to physicians within those subcontracted groups.
- Anthem notifies CMS and DHCS within seven calendar days, via the CMT, when it terminates, suspends or declines a provider from its network because of fraud, integrity or quality

Anthem decisions that are subject to an appeal include decisions regarding reduction, suspension or termination of a provider's participation resulting from quality deficiencies. Anthem notifies the National Practitioner Data Bank, the appropriate state licensing agency and any other applicable licensing or disciplinary body to the extent required by law. Written communication to the provider details the deficiencies and informs him or her of the right to appeal.

Notification to Members of Provider Termination

Anthem makes a good faith effort to provide notice to each member who received his or her care from the provider or was seen on a regular basis by the Provider within 15 calendar days of receipt or issuance of the termination notice. Anthem may provide member notification in less than 15 days' notice as a result of a provider's death or exclusion from the federal health programs.

When a termination involves a PCP or any medical, behavioral health or long-term services and supports provider all members who are patients of that provider are notified of the termination.

Providers must submit notifications to CareMore if they are terminating their contract with the plan within 120 calendar days.

For members who are receiving treatment for a chronic or ongoing medical condition or LTSS, Anthem will ensure there is no disruption in services provided.

CHAPTER 7: QUALITY MANAGEMENT

Overview

Anthem's long-standing goal has been continuous, measurable improvement in our delivery of quality health care. Following federal and state guidelines, we have a Quality Improvement (QI) program. Our QI program objectively and systematically monitors and evaluates care and service provided to members. The QI program focuses on developing and implementing standards for clinical care and service, measuring conformity to standards and taking action to improve the performance. The scope of the QI program reflects the demographic, epidemiologic, medical, behavioral health and LTSS needs of the population served. Key components of the QI program include, but are not limited to:

- Care and service provided in all health delivery settings
- Chronic disease management and prevention
- Continuity and coordination of medical care
- Community health
- Facility site review
- Medical record review
- Provider satisfaction
- Member satisfaction
- Clinical practice guidelines
- Quality of member care and service
- Accessibility and availability of services
- Member safety and prevention
- Appropriateness of service utilization
- Cultural competency
- Member outcomes
- Regulatory and accreditation standards

Anthem develops an annual work plan of quality improvement activities based on the results of the previous year's QI program evaluation. QI program revisions are made based on outcomes, trends, contractual and regulatory standards and requirements and overall satisfaction with the effectiveness of the program. The QI program evaluation is the reporting method used to evaluate the progress and results of planned activities towards established goals. QI program goals and outcomes are available to providers and members upon request.

Providers can support and participate in the Quality Improvement program by:

- Completing an annual provider satisfaction survey
- Participating in the facility and medical record audit process
- Completing corrective action plans when applicable
- Providing access to medical records for quality improvement projects and studies
- Using preventive health and clinical practice guidelines in member care
- Responding in a timely manner to requests for written information and documentation if quality of care or grievance issue has been filed

- Partnering with the health plan on potential initiatives to improve outcomes and results
- Meeting appointment scheduling time frames and access standards

The Anthem QI program tracks and trends quality of care issues and service concerns identified for all care settings. QI staff review member complaints/grievances, adverse events reports and other information to evaluate the quality of service and care provided to our members.

Practitioner/Provider Performance Data

Practitioners and providers must allow the Anthem to use performance data in cooperation with our QI program and activities.

Practitioner/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 National Committee for Quality Assurance (NCQA) and the comprehensive set of measures maintained by the National Quality Forum (NQF).

Centers for Medicare & Medicaid Services and HEDIS Metrics

The Centers for Medicare & Medicaid Services (CMS) evaluates all Medicare-Medicaid and Prescription Drug (MA-PD) plans through the use of HEDIS metrics. Many of the measures included in the CMS evaluation are measures of preventive care management. Some of these are listed below; this list is subject to change:

- Staying healthy — screening, tests and vaccines:
  - Breast cancer screening
  - Colorectal cancer screening
  - Annual flu vaccine
  - Improving and maintaining physical and mental health
  - Monitoring physical activity
  - Adult body mass index assessment
- Managing chronic conditions:
- Obtaining diabetes care for eye exams, kidney disease monitoring, and blood sugar and cholesterol control
- Controlling blood pressure
- Screening for osteoporosis in women, and managing the condition in women with a fracture
- Managing rheumatoid arthritis
- Care for the older adult: medication review, functional status assessment and pain screening
- Improving bladder control
- Reducing the risk of falling
- Plan all-cause readmissions
- Medication adherence and management (oral diabetics, hypertension and cholesterol medications)

  Statin use for people with diabetes and cardiovascular conditions

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 is ready to help when you and your office staff need training to participate in required HEDIS evaluations. Providers can request consultations and training in the following areas:

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

Our QI staff will contact your office when we need to review or copy any medical records required for HEDIS or QI studies. Requests to provider offices begin in early February connected to the annual review process, although Anthem may also request records throughout the year. Anthem requests records are 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.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

With the growing focus on quality health care and plan member satisfaction, CMS and the state assess plan performance. One of the assessment tools used is the CAHPS® survey. The CAHPS Health Plan Survey is a tool for collecting standardized information on members' experience with health plans and their services. Members who receive health care services through the Anthem Blue Cross Cal MediConnect Plan receive CAHPS surveys through the mail. Members may also receive telephone follow-ups when the mail surveys are not returned.

The survey asks the Anthem Blue Cross Cal MediConnect Plan member to assess his or her health and the care received from his or her primary care providers and specialists over the past six months. The survey includes questions regarding:

- Getting needed care
  - Easy to get an appointment with a specialist
  - Easy to get care, tests and treatment believed necessary
- Getting care quickly
  - Getting care right away (urgent)
  - Getting an appointment as soon as needed (routine)
  - Seeing a doctor within 15 minutes of their appointment time
- How well doctors communicate
  - Doctor's explanations are easy to understand
  - Doctor listened carefully
  - Doctor showed respect for what the member had to say
  - Doctor spent enough time with the member
- Health plan customer service
  - How easy it was to get information/help from the health plan
  - Representatives treated the member with courtesy and respect
  - Forms were easy to fill out

- Coordination of care
  - Doctor had medical records/care information
  - Doctor's office followed up with test results
  - The member received test results as soon as needed
  - Doctor discussed prescription medications
  - The member got the help needed to manage care
  - The member's specialist, if applicable
- Getting prescription drugs
  - Ease of getting medications prescribed
  - Ease of filling prescriptions at a pharmacy
  - Ease of filling prescriptions by mail
- Drug plan costumer service
  - Ease of getting information/help from the drug plan
  - Representatives treated the member with courtesy and respect
  - Member received information about covered medications
  - Member received information about out-of-pocket drug cost

Anthem encourages participating providers to help improve member satisfaction by:

- Ensuring members receive appointments within acceptable time frames as outlined in the Access and Availability Standards Table in this manual.
- Educating members and talking to them during each visit about their preventive health care needs.
- Answering any questions members have regarding newly prescribed medications.
- Ensuring members know to bring all medications and medical histories to their specialists and they know the purpose of a specialist referral.
- Allowing time during the appointment to validate members' understanding of their health conditions and the services required for maintaining a healthy lifestyle.
- Referring members to the Member Services department at Cal MediConnect Customer Care and speaking to a case manager if needed.

Health Outcomes Survey (HOS)

The Medicare Health Outcomes Survey (HOS) is a collection of patient-reported outcome measures used to gauge the quality of life and functional health status of members, focusing on maintaining or improving physical and mental health over time for members. The survey is administered annually to a random sample of members. Two years later, the same respondents are surveyed again. Providers can help support members and optimal outcomes by discussing important topic areas such as fall risk management, exercise or physical activity, and bladder control issues.

Committee Structure

Anthem maintains a comprehensive quality management committee structure as noted below with program oversight by the board of directors.

Quality Management Committee

The purpose of the Quality Management Committee is to provide leadership and oversight of the health plan quality management programs, improve safety and quality of care and services, improve customer service, and improve operating efficiencies.

Responsibilities include:

- Review and approval of the program descriptions
- Work plans and annual evaluations for quality management, utilization management, health promotion, credentialing, case management and pharmacy
- Review and approval reporting of complaints, appeals and Service Level Agreements (SLAs)
- Review of regular standardized reports (at least semi-annually) delineating progress towards goals of the program, actions taken, improvements made, focused study results and follow-up actions on identified opportunities
- Evaluation of resource adequacy to ensure effective implementation of the programs and ongoing effectiveness
- Recommending policy decisions
- Instituting needed actions and ensure completion
- Ensuring practitioner participation

Medicare-Medicaid Plan Quality Management Committee

The purpose of the Medicare-Medicaid Plan Quality Management Committee (MMP QMC) is to maintain quality as a cornerstone of Anthem culture and to be an instrument of change through demonstrable improvement in care and service.

The MMP QMC's responsibilities are to:

- Review and approve MMP Quality Management Trilogy documents, program descriptions, work plans and annual evaluations
- Review standardized reports reflecting progress towards clinical goals, actions taken and improvements
- Analyze, review and make recommendations regarding planning, implementation and outcomes of quality improvement projects and initiatives, as well as the Chronic Care Improvement Project (CCIP)
- Review, monitor and evaluate program compliance against state and federal standards
- Evaluate the overall effectives of the MMP Model of Care
- Review and evaluate the quality, safety, accessibility and availability of care and services for members

The MMP QMC reports to the Medicare Quality Management Committee (MQMC). The MQMC assists with monitoring and evaluation of the MMP Quality Management program from input from interdepartmental leadership.

The MMP QMC is also supported by the Medicare Medical Advisory Committee (MMAC), which includes network physicians and core members of the MMP QMC. The MMAC monitors and evaluates the MMP Quality Management program from physicians external to the organization.

Medicare Quality Management Committee (MQMC)

The MQMC's responsibilities are to:

- Review regular standardized reports, at least semi-annually, delineating progress toward clinical goals, actions taken and improvements
- Establish processes and structure that ensure CMS compliance
- Analyze, review and make recommendations regarding the planning, implementation, measurement, and outcomes of the clinical/service quality improvement projects
- Coordinate communication of quality management activities throughout Anthem
- Review CMS Stars, HEDIS, HOS and CAHPS data and action plans for improvement
- Review, monitor and evaluate program compliance against Anthem, state, federal and CMS standards
- Review LTSS credentialing issues as applicable
- Review and approve the annual Quality Management (QM) program description, work plan and program evaluation
- Evaluate the overall effectiveness of the SNP Model of Care including regular reports, performance outcomes and satisfaction, barrier analysis, effectiveness of interventions and adequacy of resources
- Oversee the compliance of delegated services and delegation oversight activities
- Assure inter-departmental collaboration, coordination and communication of quality improvement activities
- Measure compliance to medical and behavioral health practice guidelines
- Monitor continuity of care between medical and behavioral health services
- Monitor accessibility and availability
- Publicly make information available to enrollees and practitioners about the network hospital's action to improve patient safety
- Make information available about the QM program to enrollees and practitioners

Clinical Practice Guidelines

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

Anthem selects at least four evidence-based Clinical Practice Guidelines (CPGs) relevant to the member population. The guidelines are reviewed and revised by the MMP QMC at least every two years, or whenever the guidelines change.

The Anthem CPGs are located online at **https://mediproviders.anthem.com/ca**. To access the CPGs, log in to the secure site with your user name and password and select the **Clinical Practice Guidelines** link from the *Clinical Policy and Guidelines* section on the top navigation menu. A copy of the guidelines can be printed from the website.

Facility Site Review and Medical Record Review

As required by California statute, all PCP sites participating must undergo an initial site inspection and subsequent periodic site inspections, regardless of the status of other accreditation or certification. Anthem conducts these inspections every three years in order to determine:

- Provider compliance with standards for providing and documenting health care
- Provider compliance with standards for storing medical records
- Provider compliance with processes that maintain safety standards and practices
- Provider involvement in the continuity and coordination of member care

The facility site review and medical record review processes are conducted by Anthem or CareMore staff depending on the provider's office location.

Please note: The California Department of Health Care Services (DHCS) and Anthem have the right to enter provider premises 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.

Medical records and facility site review tools are available under the **Quality Improvement Program** heading on the **Provider Resources** page of our website **https://mediproviders.anthem.com/ca**.

Facility Site Reviews

A facility site review (FSR) inspection is broken down into the following six categories:

1. Access/safety
2. Personnel
3. Office management
4. Clinical services
5. Preventive services
6. Infection control

Medical Record Reviews

A medical record review (MRR) is based on a standard of 10 records per provider. Medical records will be randomly selected. The MRR inspection is broken into six sections:

1. Format
2. Documentation
3. Coordination/continuity of care
4. Pediatric preventive (if applicable)
5. Adult preventive

6. OB/Comprehensive Perinatal Services Program (CPSP) (if applicable)

The Anthem Quality Improvement team will call the provider's office to schedule an appointment date and time before the FSR due date. The team will Email, fax or mail a confirmation letter with an explanation of the audit process and required documentation. During the FSR our auditor will:

1. Lead a pre-review conference with the provider or office manager to review and discuss the process of facility review and answer any questions.
2. Conduct a review of the facility.
3. Develop a corrective action plan if applicable.

After the FSR is completed, our auditor will meet with the provider or office manager to:

1. Review and discuss the results of the FSR and explain any required corrective actions.
2. Provide a copy of the FSR results and the corrective action plan to the office manager or provider.
3. Educate the provider and office staff about our standards and policies.
4. Schedule a follow-up review for any corrective actions identified.

Providers must attain a score of 80% or greater in both the FSR and the MRR in order to pass. A corrective action plan (CAP) may also be required.

FSR and MRR: Corrective Actions

If the FSR or the MRR result 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 will develop and submit a CAP as follows:

- Correct critical deficiencies within 10 days of the FSR.
- Develop and submit a corrective action plan for all other deficiencies within 30 days.
- Sign an attestation when corrective actions are complete.

If deficiencies (other than critical) are not closed within 30 days from the date of the written CAP request or the practitioner is otherwise uncooperative with resolving outstanding issues with the facility site review, the provider will be considered noncompliant.

Critical elements include making sure sharp containers, autoclave spore testing, universal precautions, medication storage, emergency equipment and emergency medications are present and available. Facilities must demonstrate 100% percent compliance with these elements.

Provider sites that score below 80% in the FSR or MRR for two consecutive reviews must score a minimum of 80% for both FSR and MRR in the next review. Sites that don't score a minimum of 80% will be removed from the network, and the provider's members will be appropriately reassigned to other participating providers

Physical Accessibility Review (PAR)

The Facility Site Physical Accessibility Review Survey (FSR C) is conducted for providers servicing the seniors and persons with disabilities (SPD) population which includes PCPs, specialists and ancillary providers. The FSR C survey is required every three years. The results of this survey are included in the provider directory. Anthem will also make the results of the FSR C available to members in its online and paper directories.

Anthem will also offer the opportunity for the FSR C survey to any provider that requests to be evaluated, regardless of whether they are determined to be high volume.

CHAPTER 8: CLAIMS SUBMISSION AND ADJUDICATION PROCEDURES

Claims – Billing and Reimbursement

Clean claims for members are generally adjudicated within 30 calendar days from the date Anthem receives the claim. However, clean claims from providers of Medicaid covered services (for example, nursing facilities, LTSS, community behavioral health) will be processed within 45 days of receipt of the clean claim.

Anthem will pay interest charges on claims in compliance with requirements set forth in the Code of California and the demonstration between CMS, the state and the Anthem contract, as applicable.

For nonclean claims, the provider receives written notification identifying the claim number, the reason the claim could not be processed, the date the claim was received by Anthem and the information required from the provider in order to adjudicate the claim. Anthem produces and mails an Explanation of Payment (EOP) on a twice weekly basis. The EOP delineates for the provider the status of each claim that has been paid or denied during the previous week.

Anthem follows Strategic National Implementation Process (SNIP) level one through six editing for all claims received in accordance with HIPAA. Providers must bill all electronic and paper submitted claims and use HIPAA-compliant billing codes. When billing codes are updated, the provider is required to use appropriate replacement codes for submitting claims for covered services. An amendment to the participating Provider Agreement will not be required to replace such billing codes. Anthem will not reimburse any claims submitted using noncompliant billing or SNIP codes.

Providers resubmitting claims for corrections must clearly mark the claim “Corrected Claim”. Failure to mark the claim appropriately may result in denial of the claim as a duplicate. Corrected claims must be received within the applicable timely filing requirements of the originally submitted claim.

Balance Billing

Reimbursement by Anthem constitutes payment in full. Balance billing an Anthem Blue Cross Cal MediConnect Plan member is prohibited.

Claims Status

Providers should visit the Anthem website at **https://mediproviders.anthem.com/ca** or call Anthem Blue Cross Cal MediConnect Plan Customer Care at **888-291-1358** to check claims status.

Providers are encouraged to review their EDI reports from the EDI vendors and address any issues with claims submissions, such as addressing rejected claims.

Provider Claims

Providers should submit claims to Anthem as soon as possible after service is rendered; we encourage submitting claims electronically. Providers must submit electronic claims using the 837I (Institutional) or 837P (Professional) standard format. For all paper submissions, providers must use the industry standard claim form CMS-1450, also known as the UB-04 or CMS-1500 (02-12).

Claims Submission and Adjudication Procedures
CMS-1500 (08-05)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
a. OTHER INSURED'S POLICY OR GROUP NUMBER
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F
c. EMPLOYER'S NAME OR SCHOOL NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
25. FEDERAL TAX I.D. NUMBER SSN EIN
33. BILLING PROVIDER INFO & PHONE NUMBER ( )

Hospitals
CMS-1450, also known as the UB-04

5. FEDERAL TAX NUMBER
51. HEALTH PLAN I.D.

Coordination of Benefits

For the Anthem Blue Cross Cal MediConnect Plan, we will coordinate and process the claim upon initial submission from the provider.

Electronic Submission

Anthem encourages the submission of claims electronically through the Electronic Data Interchange (EDI). Providers must submit claims within the timely filing limits from the date of discharge for inpatient services or from the date of service for outpatient services.
Nursing facilities should submit claims within timely filing limits from the date the service is provided for long term services and supports.

Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan) uses Availity as its exclusive partner for managing all electronic data interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (835) allows for a faster, more efficient and cost-effective way for providers and employers to do business

Providers can also register with Availity at **www.availity.com** to become a direct submitter. To initiate the electronic claims submission process or obtain additional information, Contact Availity Client Services at **800-AVAILITY** (**800-282-4548**).
Availity Client Services is available Monday - Friday 8 a.m. - 8 p.m. ET.

Professional	Institutional	Dental
47198	47198	84103

Advantages of Electronic Data Interchange (EDI)

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

Use Availity for the following EDI transactions

Healthcare Claim: Professional (837P)

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

Ways you can use the Availity EDI Gateway

Availity's EDI submission options:

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

Electronic Data Interchange Trading Partner

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

To become an EDI Trading Partner visit **www.availity.com**.

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

Contact Availity

Please contact Availity Client Services with any questions at **800-AVAILITY** (**800-282-4548**)

Useful EDI Documentation

Availity EDI Connection Service Startup Guide - This guide includes information to get you started with submitting Electronic Data Interchange (EDI) transactions to Availity, from registration to on-going support.

Availity EDI Companion Guide - This Availity EDI Guide supplements the HIPAA TR3s and describes the Availity Health Information Network environment, interchange requirements, transaction responses, acknowledgements, and reporting for each of the supported transactions as related to Availity.

Availity Registration Page - Availity register page for users new to Availity.

Washington Publishing Company - X12 code descriptions used on EDI transactions.

Visit the EDI website (**https://www.anthem.com/ca/provider/edi**) to obtain the EDI companion guides for submitting to the Availity EDI Gateway.

EDI Submission for Corrected Claims

For corrected professional (837P) claims submitted via EDI providers should use one the following frequency codes to indicate a correction was made to a previously submitted and adjudicated claim:

7 – Replacement of prior claim
8 – Void/cancel prior claim

Note: A full definition of each code and confirmation of the use of these codes on a professional claim can be found on the National Uniform Billing Committee (NUBC) website at **www.nubc.org**.

Indicator placement:
Loop: 2300 (Claim Information)
Segment: CLM 05-03 (Claim Frequency Type code)
Value: 7, 8

For corrected institutional (837I) claims submitted via EDI, providers should use one of the following Bill Type Frequency codes to indicate a correction was made to a previously submitted and adjudicated claim:
0XX5 – Late charges only claim
0XX7 – Replacement of prior claim
0XX8 – Void/cancel prior claim

Note: A full definition of each code can be found on Pages II-111 through II-114 of the Ingenix® UB04 Billing Manual.

Indicator placement:
Loop: 2300 (Claim Information)
Segment: CLM 05-03 (Claim Frequency Type code)
Value: 5, 7, 8

Paper Claim Submission

Providers also have the option of submitting paper claims. Anthem uses optical character recognition (OCR) technology as part of its front-end claims processing procedures. The benefits include:

- Faster turnaround times and adjudication
- Claims status availability within five days of receipt
- Immediate image retrieval by Anthem staff for claims information, allowing more timely and accurate response to provider inquiries

To use OCR technology, claims must be submitted on original red claim forms (not black and white or photocopied forms) and laser printed or typed (not handwritten) in a large, dark font. Providers must submit a properly completed UB-04 or CMS-1500 (08-05) within 365 days from the date of discharge for inpatient services or from the date of service for outpatient services, except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date the third party documents resolution of the claim.

In accordance with the implementation timelines set by CMS and the National Uniform Claims Committee (NUCC), Anthem requires the use of the new CMS-1500 (08-05) for the purposes of accommodating the NPI.

In accordance with the implementation timelines set by CMS and the National Uniform Billing Committee (NUBC), Anthem requires the use of the new UB-04 CMS-1450 for the purposes of accommodating the NPI.

The CMS-1500 (08-05) and UB-04 CMS-1450 forms must include the following information (HIPAA-compliant where applicable):

- Patient's ID number
- Patient's name
- Patient's date of birth
- ICD-10 diagnosis codes/revenue codes
- Date of service
- Place of service
- Description of services rendered CPT-4 codes/HCPC codes/DRGs
- Itemized charges
- Days or units
- Provider tax ID number
- Provider name according to contract
- Anthem provider number
- NPI of billing provider when applicable
- Name of ordering physician
- NPI of ordering physician, when applicable
- Name of performing physician
- NPI of performing provider, when applicable
- State Medicaid ID number
- Coordination of benefits/other insurance information
- Authorization/precertification number or copy of authorization/precertification
- Name of referring physician
- NPI of referring physician when applicable
- Any other state required data

Anthem cannot accept claims with alterations to billing information. Claims that have been altered will be returned to the provider with an explanation of the reason for the return. Anthem will not accept claims from those providers who submit entirely handwritten claims.

Paper claims must be submitted within the timely filing limit of 365 days from the date of service. Submit paper claims to:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

Encounter Data

Anthem has established and maintains a system to collect member encounter data. Due to reporting needs and requirements, network providers who are reimbursed by capitation must

send encounter data to Anthem for each member encounter. Encounter data can be submitted through EDI submission methods or on a CMS-1500 (08-05) or a UB-04 claim form, unless other arrangements are approved by Anthem. Data will be submitted in a timely manner but no later than 12 months from the date of service.

The encounter data will include the following:

- Anthem Blue Cross Cal MediConnect Plan member ID number
- Anthem Blue Cross Cal MediConnect Plan member name (first and last name)
- Anthem Blue Cross Cal MediConnect Plan member date of birth
- Provider name according to contract
- NPI provider number
- Coordination of benefit information
- Date of encounter
- Diagnosis code
- Types of services provided (utilizing current procedure codes and modifiers if applicable)
- Provider tax ID number and state Medicaid ID number

Encounter data should be submitted to the address provided on the previous page.

HEDIS information is collected through claims and encounter data submissions. This includes but is not limited to:

- Preventive services (for example, childhood immunization, mammography, Pap smears)
- Prenatal care (for example, low birth weight, general first trimester care)
- Acute and chronic illness (for example, ambulatory follow-up and hospitalization for major disorders)

Compliance is monitored by the Anthem utilization and quality improvement staff, coordinated with the Medical Director and reported to the Quality Management Committee on a quarterly basis. The PCP is monitored for compliance with reporting of utilization. Lack of compliance will result in training and follow-up audits and could result in termination.

Claims Adjudication

Anthem is dedicated to providing timely adjudication of provider claims for services rendered to members. All network and non-network provider claims submitted for adjudication are processed according to generally accepted claims coding and payment guidelines. These guidelines comply with industry standards as defined by the CPT and ICD manuals. Institutional claims should be submitted using EDI submission methods or a CMS-1450 (UB-04), and provider claims using the CMS-1500.

Providers must use HIPAA-compliant billing codes when billing Anthem. This applies to both electronic and paper claims. When billing codes are updated, the provider is required to use appropriate replacement codes for submitted claims. Anthem will not pay any claims submitted using noncompliant billing codes.

Anthem reserves the right to use code-editing software to determine which services are considered part of, incidental to or inclusive of the primary procedure. The automated claims auditing system verifies the coding accuracy of claims for CPT and HCPCS procedures. This system ensures the same auditing criteria are applied across all claims. Editing decisions are supported by online medical coding policy statements published by CMS as a part of the National Correct Coding Initiative (NCCI, also known as CCI).

For claims payment to be considered, providers must adhere to the following time limits:

- Submit claims within the number of days specified from the date the service is rendered, or for inpatient claims filed by a hospital, within the number of days specified from the date of discharge.
- In the case of other insurance, submit the claim within the number of days specified for each market after receiving a response from the third-party payer.
- Claims for members whose eligibility has not been added to the state's eligibility system must be received within 365 days from the date the eligibility is added and Anthem is notified of the eligibility/enrollment.
- Claims submitted after the timely filing deadline will be denied.

After filing a claim with Anthem, review the twice weekly EOP. If the claim does not appear on an EOP within 30 business days as adjudicated or you have no other written indication the claim has been received, check the status of your claim by using the Anthem website at **https://mediproviders.anthem.com/ca** or by calling Provider Services at Anthem Blue Cross Cal MediConnect Plan Customer Care at **888-291-1358**. If the claim is not on file with Anthem, resubmit your claim within 365 days from the date of service. If filing electronically, check the confirmation reports for acceptance of the claim you receive from your EDI or practice management vendor.

Clean Claims Payment

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

- Submitted in a timely manner
- Free of defects
- Submitted on a HIPAA-compliant standard claim form CMS-1500 (02-12) or CMS-1450 (UB-04) or successor forms thereto (or the electronic equivalent)
- Does not require developing, outreach to an external source, adjustment or alteration by the provider or by a third party in order to be processed and paid by Anthem

Clean claims are typically adjudicated within 30 calendar days of receipt or within 14 days, as required for Medicaid services. Anthem will pay all applicable interest as required by law on clean claims not adjudicated within the timeframes specified above.

Anthem produces and mails an explanation of payment (EOP) twice per week. The EOP delineates for the provider the status of each claim adjudicated during the previous payment cycle.

Electronic claims determined to be unclean will be returned to the Anthem contracted clearinghouse that submitted the claim.

In accordance with CMS requirements, Anthem will adjudicate at least 90% of all clean claims within 30 calendar days of the date of receipt. However, clean claims from providers of Medicaid covered services (for example, nursing facilities, LTSS, community behavioral health) should be processed within 45 days of receipt of the clean claim.

ICD-10 Description

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

International classification of diseases, 10th Revision (ICD-10) is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaces the International classification of diseases, 9th Revision (ICD-9), which was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes. 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:

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

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

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

Anthem offers Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) with online viewing capability. Providers can elect to receive Anthem payments electronically through direct-deposit to their bank account. In addition, providers can select from a variety of remittance information options, including:

- HIPAA-compliant data file for download directly to your practice management or patient accounting system
- Paper remittance printed and mailed by Anthem

Some of the benefits providers may experience include:

- Faster receipt of payments from Anthem

- The ability to generate custom reports on both payment and claim information based on the criteria specified
- Online capability to search claims and remittance details across multiple remittances
- Elimination of the need for manual entry of remittance information and user errors

Electronic Funds Transfer (EFT)

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

Visit **https://www.anthem.com/ca/provider/edi** for EFT registration instructions.

Electronic Remittance Advice (835)

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

1. Log in to Availity at www.availity.com
2. Select **My Providers**
3. Click on **Enrollment Center** and select **Transaction Enrollment**

Specialist Reimbursement

Specialty care providers must obtain Anthem approval prior to rendering or arranging any treatment that is beyond the specific treatment authorized or beyond the scope permitted under this program.

Specialty care provider services will be covered only when there is documentation of appropriate notification or prior authorization as appropriate, and receipt of the required claims and encounter information to Anthem.

Reimbursement Policies

Reimbursement policies serve as a guide to assist you with accurate claims submissions and outline the basis for reimbursements when services are covered by Anthem Blue Cross Cal MediConnect Plan. The determination that a service, procedure, item, etc. 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. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claims submissions. Services should be billed with CPT codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

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

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

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

Reimbursement Hierarchy

Claims submitted for payments must meet all aspects of criteria for reimbursements. 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 methodologies are considered to be conditions of payments.

Review Schedule and Updates

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

Medical Coding

The Medical Coding department ensures that correct coding guidelines have been applied consistently through Anthem. Those guidelines include, but are not limited to:

- Correct modifier use
- Effective date of transaction code sets (CPT, HCPCS, ICD diagnosis/procedures, revenue codes, etc.)
- Code editing rules are appropriately applied and within regulatory requirements
- Analysis of codes, code definition and appropriate use

Reimbursement by Code Definition

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

- Evaluation and management

- Anesthesia
- Surgery
- Radiology (nuclear medicine and diagnostic imaging)
- Pathology and laboratory
- Medicine
- Category II codes: supplemental tracking codes that can be used for performance measurement
- Category III codes: temporary codes for emerging technology, services or procedures

Documentation Standards for an Episode of Care

When Anthem requests clinical documentation from you to support claims payments for services, you must ensure the information provided to us:

- Identifies the member
- Is legible
- Reflects all aspects of care

To be considered complete, documentation for episodes of care will include, at a minimum, the following elements:

- Patient identifying information
- Consent forms
- Health history, including applicable drug allergies
- Types and dates of physical examinations
- Diagnoses and treatment plans for individual episodes of care
- Physician orders
- Face-to-face evaluations
- Progress notes
- Referrals
- Consultation reports
- Laboratory reports
- Imaging reports (including X-ray)
- Surgical reports
- Admission and discharge dates and instructions
- Preventive services provided or offered appropriate to the member's age and health status
- Evidence of coordination of care between primary and specialty physicians

Refer to the standard data elements to be included for specific episodes of care as established by The Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A single episode of care refers to continuous care or a series of intervals of brief separations from care to a member by a provider or facility for the same specific medical problem or condition. Documentation for all episodes of care must meet the following criteria:

- Legible to someone other than the writer
- Contains information that identifies the member on each page in the medical record
- Contains entries in the medical record that are dated, with author identification (for example, handwritten signatures, unique electronic identifiers or initials)

Other Documentation Not Related to the Member

Other documentation not directly related to the member but relevant to support clinical practice may be used to support documentation regarding episodes of care, including:

- Policies, procedures and protocols
- Critical incident/occupational health and safety reports
- Statistical and research data
- Clinical assessments
- Published reports/data

Anthem may request that you submit additional documentation, including medical records or other documentation not directly related to the member, to support claims you submit. If documentation is not provided following the request or notification or if documentation does not support the services billed for the episode of care, we may:

- Deny the claim
- Recover and/or recoup monies previously paid on the claim

Anthem is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.

Overpayment Process

Refund notifications may be identified either by Anthem's Cost Containment Unit (CCU) or the provider. The CCU researches and notifies the provider of an overpayment by requesting a refund check. The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

Once an overpayment has been identified, Anthem will notify the provider of the overpayment. The provider will submit a Refund Notification form along with the refund check. If you identified the overpayment and return the Anthem check, please include a completed Refund Notification form specifying the reason for the return. This form can be found on the provider website at **https://mediproviders.anthem.com/ca**. Submission of the Refund Notification form will allow the CCU to process and reconcile the overpayment in a timely manner. Once the CCU has reviewed the overpayment, you will receive a confirmation letter explaining the details of the reconciliation. For questions regarding the refund notification procedure, please call Provider Services at Anthem Blue Cross Cal MediConnect Plan Customer Care at **888-291-1358**.

Anthem uses an automated claims auditing system to ensure claims are adjudicated in accordance with industry billing and reimbursement standards. Claims auditing software ensures compliance with an ever-widening array of edits and rules as well as consistency of

payment for providers, by ensuring correct coding and billing practices are being followed. Using a sophisticated auditing logic, our code editing system determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesia codes and processes those services according to the NCCI. NCCI was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. NCCI code pair edits are automated prepayment edits that prevent improper payment when certain codes are submitted together for Part B-covered services.

In addition to code pair edits, the NCCI includes a set of edits known as medically unlikely edits (MUEs). An MUE is a maximum number of units of service (UOS) allowable under most circumstances for a single HCPCS/CPT code billed by a provider on a date of service for a single beneficiary.

CHAPTER 9: PROVIDER DISPUTES AND APPEALS PROCEDURES

Overview

Providers are not penalized for filing disputes or appeals. All provider complaints will be resolved fairly and consistently with Anthem policies, covered benefits and the provider's contract.

Appeals and Disputes

Disputes and appeals that are the result of contractual issues between the provider and Anthem carry no member liability, and the member is held harmless for any payment. It is important to follow the directions in the denial letter issued to ensure the proper complaint process is followed. The provider dispute process is located under the section titled *Provider Payment Disputes*. The provider appeal process is located under the section titled *Provider Appeals*. Denials which assign member liability are described in the section titled *Member Appeals*.

Provider Payment Disputes

If you believe Anthem has not paid for your services according to the terms of your Provider Agreement or wish to dispute a timely filing denial or submit a second request of a claim reconsideration, submit a request using the *Provider Dispute Resolution Request* form located online under *Forms* at **https://mediproviders.anthem.com/ca**.

Note: Providers will not be penalized for filing a payment dispute.

Submit provider payment disputes to:

Provider Payment Disputes
Anthem Blue Cross
P.O. Box 61599
Virginia Beach, VA 23466

The Provider Disputes Unit will receive, distribute and coordinate all payment disputes.

1. Submit a written request with supporting documentation, such as an EOP and a copy of the claims or denial letter received, along with other written documentation; a full explanation of the dispute is required and must be submitted within 120 days of when the Anthem notice of initial determination was generated, or we will not accept the request. The provider is responsible for submitting all necessary documentation at the time of the request.
2. The Anthem Claims department conducts the review, and/or the health plan Medical Director reviews the second level dispute if medical information is involved; if additional information is submitted that would support payment, the denial is overturned.
3. An internal review is conducted and results communicated in a written decision to the provider within 45 calendar days. The written decision includes:
    - A statement of the provider's dispute

- The reviewer's decision along with a detailed explanation of the contractual and/or medical basis for the decision
- A description of the evidence or document that supports the decision

Provider Payment Appeals

The provider appeal process is used to address the request for reconsideration of the denial of payment for a service. The denial reasons include inappropriate site of service, lack of medical necessity, no prior authorization and noncovered services.

Provider appeals must be submitted in writing. Any supporting documentation should accompany the appeal request and be forwarded to:

Complaints, Appeals and Grievances Department
Anthem Blue Cross
Mailstop: OH0205-A537
4361 Irwin Simpson Rd.
Mason, OH 45040
Fax: **888-458-1406**

Member Liability Appeals

A member liability appeal is the type of request made to request that Anthem reconsider and change an initial coverage/organization determination (issued by Anthem or a delegated provider) about a preservice denial of authorization for medical items or services or Part D prescription drugs, or a post-service denial of a claim denied with member liability.

Member liability appeals include, but are not limited to:

- An adverse initial organization determination by Anthem or a provider concerning authorization for or termination of coverage of a health care service
- An adverse initial organization determination by Anthem concerning a refusal to reimburse for a health service already received if the refusal would result in the member being financially liable for the service
- An adverse coverage determination by Anthem or a provider concerning authorization or reimbursement for prescription drugs

Scenarios that do not meet member liability appeals guidelines:

- Inappropriate site of service
- Bundled services
- Timely filing denials
- Invalid diagnosis, procedure and modified denial
- Claims denied with provider liability

Member liability appeals must be filed within 90 days of the Anthem notification of the denial. The request may be made telephonically or in writing.

Appeals should be sent to:

Complaints, Appeals and Grievances Department
Anthem Blue Cross
Mailstop: OH0205-A537
4361 Irwin Simpson Rd.
Mason, OH 45040
Phone:
888-350-3447 for Santa Clara County and 855-817-5785 for Los Angeles County
Fax: **888-458-1406**

Non-Physician Providers may have to complete an *Appointment of Representative* form to submit an appeal on behalf of an Anthem Blue Cross Cal MediConnect Plan member, The *Appointment of Representative* form can be found online and downloaded at: **https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**. Providers can also obtain a signed written statement from the member.

Response to Request for Additional Information

Providers must cooperate with Anthem and with members in providing necessary information to resolve the appeals within the required time frames. Providers must provide the pertinent medical records and any other relevant information upon request and when initiating an appeal. In some instances, providers must provide the records and information very quickly in order to allow Anthem to make an expedited decision. Your participation in and the member's election of the coordinated care plan are an indication of consent to release those records as part of the health care operations.

Member Liability – Appeal Time Frame Table

Medicare member appeals have standard and expedited processes as shown below.

Type of Appeal	Timeline for Submission	Applies to	Standard Turnaround Time	Expedited Turnaround Time
Payment	60 calendar days from EOP	Denied payment for a service already received	Within 30 calendar days *A 14 day extension may be applied	Not available
Preservice Medical	60 calendar days from denial letter	Denied request for a health service or item not already received	Within 30 calendar days *A 14 day extension may be applied	Within 72 hours *A 14 day extension may be applied
Preservice Prescription drugs	60 calendar days from denial letter	Denied request for a prescription drug not already received	Within seven calendar days	Within 72 hours
Discontinuation of SNF, HHA or CORF services		Discontinuation of SNF, HHA, and CORF services previously approved and no longer determined to be medically necessary (does not apply to preservice or benefit denials).	Appeals should be lodged as per the denial letter issued to the appropriate QIO within the applicable time frame. The QIO will provide an immediate review.	

Type of Appeal	Timeline for Submission	Applies to	Standard Turnaround Time	Expedited Turnaround Time
Discontinuation of inpatient hospital care		When a Medicare member receives the "Important Message from Medicare" when being discharged from the hospital.	Appeals should be lodged as per the denial letter issued to the appropriate QIO within the applicable time frame. The QIO will provide an immediate review. If the time frame has been missed, the appeal can be lodged with the Grievances and Appeals department and the request will be reviewed as expedited (within 72 hours).	

If the normal time period for an appeal could jeopardize the member's life, health or ability to regain maximum function, the member or the member's physician can request an expedited appeal. Such appeals generally are resolved within 72 hours, unless it is in the member's interest to extend this time period by up to 14 calendar days. If a physician requests the expedited appeal and indicates the case meets the expedited criteria, Anthem will automatically expedite the appeal.

Further Appeal Rights

If Anthem is unable to reverse the original denial decision in whole or part, the following additional steps will be taken:

- Medicare covered services
  - Anthem will forward the appeal to an independent review entity (IRE) contracted with the federal government. The IRE will review the appeal and make a decision:
    - Within 72 hours if expedited
    - Within 30 days if the appeal is related to authorization for health care
    - Within 60 days if the appeal involves reimbursement for care
  - Prescription drug appeals are not forwarded to the IRE by Anthem but may be requested by the member or representative; information will be provided throughout the appeals process.
  - If the IRE issues an adverse decision (in other words, not in the member's favor) and the amount at issue meets a specified dollar threshold, the member may appeal to an administrative law judge (ALJ).
  - If the member is not satisfied with the ALJ's decision, the member may request review by the Medicare Appeals Council. If the Medicare Appeals Council refuses to hear the case or issues an adverse decision, the member may be able to appeal to a federal court.
- Medicaid covered services
  - Only covered under Medicaid (DHCS), including LTSS, covered non-Part D Drugs and behavioral health
  - The appeal may be filed externally by the member to the DHCS Appeals Division
  - A response will be issued within 72 hours for an expedited appeal

    - During the first year of the demonstration, a response will be issued within 90 calendar days (75 calendar days in year two and 30 calendar days in subsequent years)
- Medicare and Medicaid covered services
    - Any appeals that overlap Medicare and Medicaid (including, but not limited to: home health, durable medical equipment and skilled therapies, but excluding Part D) will be automatically forwarded to the IRE. The member may also submit a request to the DHCS Appeals Division. Anthem will be bound to the outcome that is more favorable to the member.

Noncontracted Providers – Medicare Advantage/Medicare Medicaid Plans

If a claim is partially or fully denied for payment, the noncontracted provider must request a reconsideration of the denial within 60 calendar days from the remittance notification. When submitting the reconsideration of the denial of payment on a claim, a signed *Waiver of Liability* form must be included. To obtain this form, please go to **https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c13.pdf** and select **Appendix 7**. The purpose of the *Waiver of Liability* form is to hold the enrollee harmless regardless of the outcome of the appeal.

With the appeal, the noncontracted provider should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's argument for reimbursement. The appeal must be in writing and mailed.

Please mail the appeal to:

Grievances and Appeals
Anthem Blue Cross
Mailstop: OH0205-A537
4361 Irwin Simpson Rd.
Mason, OH 45040

Member Grievance

A member grievance is the type of complaint a member makes regarding any other type of problem with Anthem or a provider. For example, complaints concerning quality of care, long wait times for appointments or in the waiting room and complaints about the cleanliness of the provider’s facilities are all grievances.

Anthem must accept grievances from members orally or in writing within 60 days of the event. Anthem must make a decision and respond to the grievance within 30 days. Anthem can request up to 14 additional days to respond to a grievance with good reason. The 14 day extension does not apply to grievances related to Medicaid only services (in other words, LTSS, covered non-Part D drugs and behavioral health).

Member Grievance Submission Process

If a member has a grievance about Anthem, a provider or any other issue, providers should instruct the member to call Member Services at **888-350-3447 for Santa Clara County and 855-817-5785 for Los Angeles County**. TTY users should call **1-800-855-2880** during regular business hours or send a written grievance to:

Complaints, Appeals and Grievances Department
Anthem Blue Cross Mailstop: OH0205-A537
4361 Irwin Simpson Rd
Mason, OH 45040
Fax: **888-458-1406**

Anthem will display a link on its main page to the electronic grievance form located at **https://www.medicare.gov**.

CHAPTER 10: MEMBER RIGHTS AND RESPONSIBILITIES

Overview

Providers are required to adhere to Centers for Medicare & Medicaid Services (CMS), DHCS, and Anthem requirements concerning issuing letters and notices.

Anthem Blue Cross Cal MediConnect Plan members have the right to timely quality care and treatment with dignity and respect. Providers must respect the rights of all Anthem Blue Cross Cal MediConnect Plan members.

A member has the right to:

- Be treated with dignity and respect
- Be afforded privacy and confidentiality in all aspects of care and for all health care information, unless otherwise required by law
- Be provided a copy of his or her medical records, upon request, and to request corrections or amendments to these records
- Not to be discriminated against based on race, ethnicity, national origin, religion, sex, age, sexual orientation, medical or claim history, mental or physical disability, genetic information, or source of payment
- Have all plan options, rules, and benefits fully explained, information about the organization, its services, its practitioners and providers and member rights and responsibilities, including through use of a qualified interpreter if needed
- Access to an adequate network of primary and specialty providers who are capable of meeting the his or her needs with respect to physical access, communication and scheduling needs, and are subject to ongoing assessment of clinical quality including required reporting
- Choose a plan and provider at any time, including a plan outside of the demonstration, and have that choice be effective the first calendar day of the following month
- Have a voice in the governance and operation of the integrated system, provider or health plan and make recommendations regarding the organization's member rights and responsibilities policy
- Participate in all aspects of care and to exercise all rights of appeal
- Receive a health risk assessment upon enrollment in a plan and to participate in the development and implementation of a plan of care. The assessment must include considerations of social, functional, medical, behavioral, wellness and prevention domains, an evaluation of the member's strengths and weaknesses and a plan for managing and coordinating member's care. Members, or their designated representatives, also have the right to request a reassessment by the interdisciplinary team and be fully involved in any such reassessment.
- Receive complete and accurate information on his or her health and functional status by the interdisciplinary team
- Be provided information on all program services and health care options, including available treatment options and alternatives, regardless of cost or benefit coverage,

presented in a culturally appropriate manner, taking into consideration the member's condition and ability to understand. The member may participate in making decisions about their health care. When a participant is unable to participate fully in treatment decisions has the right to designate a representative. This includes the right to have translation services available to make information appropriately accessible. Information must be available:
    - Before enrollment
    - At enrollment
    - At the time a participant's needs necessitate the disclosure and delivery of such information in order to allow the participant to make an informed choice
- Be encouraged to involve caregivers or family members in treatment discussions and decisions
- Have advanced directives explained and to establish them, if the participant so desires
- Receive reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer
- Be afforded the opportunity to file an appeal if services are denied that he or she thinks are medically indicated, and to be able to ultimately take that appeal to an independent external system of review
- Voice complaints or appeals about the organization or the care it provides
- Receive medical and nonmedical care from a team that meets the member's needs, in a manner that is sensitive to the member's language and culture, and in an appropriate care setting, including the home and community
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Be free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the health plan, providers or the state agency treat the member
- Receive timely information about plan changes. This includes the right to request and obtain the information listed in the orientation materials at least once per year, and the right to receive notices of any significant change in the information provided in the orientation materials at least 30 days prior to the intended effective date of the change.
- Be protected from liability for payment of any fees that are the obligation of the health plan
- Not to be charged any cost sharing for Medicare Part A and B services

Members have the responsibility to:

- Be fully involved in maintaining his or her health and making decisions about their health care, develop treatment goals and the right to refuse treatment if desired, and must be appropriately informed and supported to this end
- Provide his or her health care provider with accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters related to his or her health to the best of his or her knowledge
- Report unexpected changes in his or her condition to their provider

- Report to their provider whether he or she understands a suggested course of action and what is expected of him or her
- Follow their mutually agreed upon treatment plan recommended by their provider
- Keep appointments and, when unable to do so for any reason, notify the provider or health care facility
- Be responsible for his or her actions if refusing treatment or not following their provider's instructions
- Ensure the financial obligations of his or her health care are fulfilled as promptly as possible
- Follow health care facility rules and regulations affecting patient care and conduct
- Notify Anthem if they have questions, concerns, problems or suggestions (members may call Anthem Member Services at **888-350-3447 for Santa Clara County and 855 817-5785 for Los Angeles County (TTY 711)**

CHAPTER 11: FRAUD AND ABUSE

General Obligations to Prevent, Detect and Deter Fraud, Waste and Abuse

As a recipient of funds from state and federally sponsored health care programs, Anthem has a duty to help prevent, detect and deter fraud, waste and abuse. Anthem is committed to detecting, mitigating and preventing fraud, waste and abuse. As part of the requirements of the federal Deficit Reduction Act, each provider is required to adopt Anthem policies on detecting, preventing and mitigating fraud, waste and abuse in all the federally and state funded health care programs in which Anthem participates.

The Anthem policy on fraud, waste and abuse prevention and detection is part of the Anthem Compliance program. Electronic copies of this policy and the Code of Business Conduct and Ethics can be found on the website at **https://www.anthemcorporateresponsibility.com/ethics-and-integrity**.

Anthem maintains several ways to report suspected fraud, waste and abuse. As a participant in government-sponsored health care, you and your staff are obligated to report suspected fraud, waste and abuse. The type of possible fraud that is observed misconduct, including violations of the Code, company policies and procedures, laws and regulations or other ethical concerns, should be reported to the Ethics Office. There are various channels to submit reports.

Allegations of fraud perpetrated by a provider of member can be reported to the Special Investigations Unit (SIU). These reports can be made anonymously at **https://www.fighthealthcarefraud.com**. In addition to anonymous reporting, suspected fraud, waste and abuse may also be reported by calling Anthem Blue Cross Cal MediConnect Plan Customer Care at **888-291-1358**.

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

Importance of Detecting, Deterring and Preventing Fraud, Waste and Abuse

Health care fraud costs taxpayers increasingly more money every year. State and federal laws are designed to crack down on these crimes and impose strict penalties. Fraud, waste and abuse in the health care industry may be perpetuated by every party involved in the health care process. There are several stages to inhibiting fraudulent acts, including detection, prevention, investigation and reporting. In this section, Anthem educates providers on how to help prevent member and provider fraud by identifying the different types, for example: .

Provider Fraud, Waste and Abuse

- Billing for services not rendered
- Billing for services that were not medically necessary

- Double billing
- Unbundling
- Upcoding

Member Fraud, Waste and Abuse

- Benefit sharing
- Collusion
- Drug trafficking
- Forgery
- Illicit drug seeking
- Impersonation fraud
- Misinformation/misrepresentation
- Subrogation/third-party liability fraud
- Transportation fraud

Providers can prevent fraud, waste and abuse by ensuring the services rendered are medically necessary, accurately documented in the medical records and billed according to American Medical Association guidelines and use appropriate, accepted coding methods.

To help prevent fraud, waste and abuse, providers can educate members about these types of fraud and the possible penalties that may be levied. Spending time with patients and reviewing their records for prescription administration will help minimize drug fraud and abuse. One of the most important steps to help prevent member fraud is as simple as reviewing the Anthem Blue Cross Cal MediConnect Plan member ID card. It is the first line of defense against fraud. Anthem may not accept responsibility for the costs incurred by providers rendering services to a patient who is **not** an Anthem Blue Cross Cal MediConnect Plan member, even if that patient presents a member ID card. Providers should take measures to ensure the cardholder is the person named on the card.

Additionally, encourage members to protect their cards as they would a credit card or cash, carry their Anthem Blue Cross Cal MediConnect Plan member ID card at all times, and report any lost or stolen cards to Anthem as soon as possible.

Anthem believes awareness and action are vital to keeping the state and federal programs safe and effective. Understanding the various opportunities for fraud, waste and abuse and working with members to protect their Anthem Blue Cross Cal MediConnect Plan ID card can help prevent fraud, waste and abuse. Anthem encourages its members and providers to report any suspected instance of fraud, waste and abuse using the contact methods referenced earlier. No individual who reports violations or suspected fraud, waste or abuse will be retaliated against. Anthem will make every effort to maintain anonymity and/or confidentiality.

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA, also known as the Kennedy-Kassebaum Bill) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of health care fraud and simplifies the administration of health insurance.

Anthem strives to ensure both Anthem and contracted participating providers conduct business in a manner that safeguards patient/member information in accordance with the privacy regulations enacted pursuant to HIPAA. Providers must have the following procedures in effect as of April 14, 2003, to demonstrate compliance with the HIPAA privacy regulations.

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

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

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

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

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

When contacting Anthem, providers should be prepared to verify their name, address and tax identification number (TIN) or NPI.

CHAPTER 12: GLOSSARY OF TERMS

AAPSF: Accreditation Association for Podiatric Surgical Facilities

AAAHC: Accreditation Association for Ambulatory Health Care

AAAASF: American Association for Accreditation of Ambulatory Surgery Facilities

ABMS: American Board of Medical Specialties

ABCN: American Board of Clinical Neuropsychology

ABPN: American Board of Professional Neuropsychology

ACHC: Accreditation Commission for Health Care

AOA: American Osteopathic Association

APA: American Psychological Association

Appeal: Appeals are any of the procedures that deal with the review of adverse organization or coverage determinations on the health care services or prescription drug benefits a member is entitled to receive or any amounts the member must pay for a covered service. These procedures include reconsiderations by Anthem, the Part D Quality Improvement Council, hearings before an administrative law judge, reviews by the Medical Appeals Council and federal judicial reviews. This process is separate from the provider administrative appeals/dispute process.

Attestation: A signed statement indicating that a practitioner or health delivery organization (HDO) designee personally confirmed the validity, correctness and completeness of his, her or its credentialing application at the time that he, she or it applied for participation.

CACREP: Council for Accreditation of Counseling and Related Educational Programs

CARF: Commission on Accreditation of Rehabilitation Facilities

CASWE: Canadian Association for Social Work Education

Certification: Board certification as recognized by the American Board of Medical Specialties, the American Osteopathic Association, the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, the American Board of Orthopedic and Primary Podiatric Medicine, the American Board of Podiatric Surgery or the American Board of Oral and Maxillofacial Surgery.

CHAMPUS: The Civilian Health and Medical Program of the Uniformed Services (in the United States); CHAMPUS is a federally funded health program that provides beneficiaries with medical care supplemental to that available in military and public health service (PHS) facilities.

CHAP: Community Health Accreditation Program

CHEA: Council for Higher Education Accreditation; an agency recognized by the company which publishes a reference used to verify the status of educational programs.

CMS: Centers for Medicare & Medicaid Services; the federal agency under the Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

COAMFTE: Committee on Accreditation for Marriage and Family Therapy Education

Company Credentials Committee (CC): A local credentialing and peer review body authorized to make decisions regarding the credentials of all practitioners and HDOs initially applying for and those requesting continued participation in the Anthem Blue Cross Cal MediConnect Plan network.

Company Medical Directors: Those Medical Directors with responsibility for the Medical Operations and Quality Management activities.

Covered services: Those benefits, services or supplies that are:

- Provided or furnished by providers or authorized by Anthem or its providers.
- Emergency services and urgently needed services that may be provided by nonparticipating providers.
- Renal dialysis services provided while members are temporarily outside the service area.
- Basic and supplemental benefits.

Credentialing staff: Any associate in the Credentialing department.

CSWE: Council on Social Work Education

Emergency medical condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.

Emergency services: Covered inpatient and outpatient services that are furnished by a provider qualified to furnish such services, and that are needed to evaluate or stabilize an enrollee's emergency medical condition.

Experimental procedures and items: Procedures and items determined by Anthem and Medicare not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, Anthem will follow CMS guidance (via the Medicare Carriers Manual and Coverage Issues Manual) if applicable or CMS guidance already made by Medicare and Medicaid.

Exceptions: An exception request is a type of coverage determination request. Through the exception process, the member can request an off-formulary drug, an exception to the Anthem tiered cost-sharing structure or an exception to the application of a cost utilization management tool (for example, step therapy requirement, dose restriction or precertification requirement).

Fee-for-service Medicare: A payment system by which doctors, hospitals and other providers receive a fee for each service such as an office visit, test, procedure or other health care service.

Formal appeal: The process by which Anthem's adverse credentialing decision is challenged.

Grievance: A complaint or dispute other than one involving an organization determination. Examples of issues involving a complaint that is resolved through the grievance rather than the appeal process are waiting times in physician offices and rudeness or unresponsiveness of customer service staff.

Healthcare Integrity and Protection Data Bank (HIPDB): The national databank maintained by the U.S. Department of Health and Human Services or its designated contractor, created pursuant to HIPAA to combat fraud and abuse in the health insurance and health care delivery system.

Health delivery organization (HDO): A facility, institution or entity that is licensed in accordance with all applicable state and/or federal laws, that provides or delivers health care services.

HFAP: Healthcare Facilities Accreditation Program (a program of the American Osteopathic Association formerly referred to as AOACHA - American Osteopathic Association Committee on Hospital Accreditation).

Home health agency: A Medicare-certified home health agency is one that provides intermittent skilled nursing care and other therapeutic services in a member's home when medically necessary, when members are confined to their home and when authorized by their PCP.

Hospice: A Medicare-certified organization or agency primarily engaged in providing pain relief, symptom management and support services to terminally ill people and their families.

Hospital: A Medicare-certified institution licensed by the state that provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term hospital does not include a convalescent nursing home, rest facility or facility for the aged that furnishes primarily custodial care, including training in routines of daily living.

Immediate termination: A termination of network participation which is effective immediately. It occurs prior to review by the committee and prior to the provider/HDO being allowed an appeal. It is used when determined necessary by Anthem to protect against imminent danger to the health or welfare of its members.

IMQ: Institute for Medical Quality

Independent practice association: A group of physicians that function as a contracting medical provider/group but in which the individual member physicians operate their respective independent medical offices.

Informal review/reconsideration: A process through which a practitioner or HDO is given the opportunity to submit additional information to Anthem for its consideration. Reviewer(s) may be the same person(s) who were part of the original decision. As part of the informal review/reconsideration Anthem, at its discretion, may afford additional privileges to the practitioner or HDO, such as by way of example only, an opportunity to discuss the decision with an Anthem representative telephonically. In any event, an informal review/reconsideration shall not include privileges equal to or greater than those offered in a formal appeal.

Initial applicant: Any person or organization that provides health care services which has applied for participation with Anthem to provide health care services to Anthem Blue Cross Cal MediConnect Plan members.

Medicaid: The federal health insurance program established by Title XIX of the Social Security Act and administered by states for low-income individuals.

Medically necessary: Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. 1395y. We make determinations of medical necessity based on peer-reviewed medical literature, publications, reports and evaluations; regulations and other types of policies issued by federal government agencies, Medicare local carriers and intermediaries; and such other authoritative medical sources as deemed necessary by Anthem.

Medicare: The federal health insurance program established by Title XVIII of the Social Security Act and administered by the federal government for elderly and disabled individuals.

Member: A Medicare and Medicaid beneficiary entitled to receive covered services, who are enrolled in the Anthem Blue Cross Cal MediConnect Plan and whose enrollment has been confirmed by CMS.

National Credentials Committee: A committee composed of Anthem's Medical Directors, Medical Director of Medical Policy and Credentialing and chaired by the Vice President of Medical Policy, Technology Assessment and Credentialing. It is responsible for the development and maintenance of a consistent national credentialing policy. This committee shall establish policy governing all aspects of credentialing of network practitioners and HDOs, including but not limited to scope, criteria, confidentiality, delegation and appeals.

National Credentialing Policy: Policy defined by National Credentials Committee and set forth in this document.

NIAHO: National Integrated Accreditation for Healthcare Organizations

National Practitioner Data Bank (NPDB): A federal data bank maintained by the U.S. Department of Health & Human Services or its authorized contractor, which houses information regarding providers and any state or federal sanctions, closed malpractice cases where findings are for the plaintiff, settlements and hospital privilege actions.

National Register of Health Service Providers in Psychology (The Register): An organization providing primary source verification for education and training and Board Certification of psychologists. This entity has "deemed status" from NCQA.

Participating provider: Any person or organization, including practitioners and facilities, that provides health care services and has entered into an agreement with Anthem to provide health care services to Anthem Blue Cross Cal MediConnect Plan members.

Peer review: Evaluation or review of the professional competency and conduct of colleagues by professionals with similar types and degrees of expertise (for example, the evaluation of one physician's practice by another physician).

Practitioner: An individual person who is licensed in accordance with all applicable state and federal laws to deliver health care services.

Primary care providers and/or primary care physicians (PCPs): Physicians who elect and are selected as PCPs and who practice in the following specialties: pediatrics, internal medicine, family practice, geriatricians and general practice.

Professional review action: A decision to terminate or reject a provider from network participation that is based on the competence or professional conduct of a provider, which affects or could adversely affect the health or welfare of a patient.

Provider: Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the state and/or Medicare to deliver or furnish health care services. This individual or organization has a contract directly or indirectly with Anthem to provide services directly or indirectly to Medicare members pursuant to the terms of the participating Provider Agreement.

Provider payment dispute: A request for Anthem to review the claim adjudication when the provider feels payment was not rendered as per the contractual agreement between Anthem and the provider.

Service area: A geographic area approved by CMS within which an eligible individual may enroll in a Medicare Advantage plan. The geographic area for Anthem is located in the Summary of Benefits document.

Specialty: Those fields of clinical practice recognized by Anthem's Credentialing program

TJC: The Joint Commission

Urgently needed services: Those covered services provided when the member is temporarily absent from the Medicare Advantage service area or under unusual and extraordinary circumstances; when the member is in the service area but the member's PCP is temporarily unavailable or inaccessible; when such services are medically necessary and immediately required as a result of an unforeseen illness, injury or condition; and when it is not reasonable given the circumstances to obtain the services through the PCP.

* Availity, LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan). IngenioRx, Inc. is an independent company providing pharmacy benefit management services on behalf of Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan). VSP is an independent company providing vision services on behalf of Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan). American Logistics is an independent company providing transportation services on behalf of Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan).