



Anthem Blue Cross and Blue Shield Provider and Facility Manual

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Introduction and Guide to Manual

[Purpose and Introduction](#)

Anthem Blue Cross and Blue Shield and our subsidiary company, HMO Colorado (hereinafter collectively referred to as "Anthem"), are independent licensees of the Blue Cross and Blue Shield Association. We each maintain a network of independent physicians, multi-specialty group practices, ancillary providers and health care facilities contracted to provide health care services to our Covered Individuals.

This Manual is intended to support all entities and individuals that have contracted with Anthem. The use of "Provider" within this manual refers to entities and individuals

contracted with Anthem that bill on a CMS 1500. They may also be referred to as Professional Providers in some instances. The use of “Facility” within this manual refers to entities contracted with Anthem that bill on a UB 04, such as Acute General Hospitals and Ambulatory Surgery Centers. General references to “Provider Inquiry”, “Provider Website”, “Provider Network Manager” and similar terms apply to both Providers and Facilities.

We know how complicated the health insurance and managed care industry has become, and we understand how that complexity can affect your office or facility. The Manual contains information about claims submission, reimbursement processes and methodology, authorizations, who to contact at Anthem and other key information to make your relationship with us run as smoothly as possible.

Anthem retains the right to add to, delete from and otherwise modify this Manual. Providers and Facilities must acknowledge this Manual and any other written materials provided by Anthem as proprietary and confidential. If there is a conflict with the Manual and your Agreement, your Agreement supersedes. We encourage you to contact your Anthem contracting representative whenever you need clarification or if you have any suggestions for improvement to the Manual. If you don't know who your assigned contracting representative is, please reference the [Escalation Contact List](#), or go to **anthem.com**, select the **Provider** link in top center of the page. Select **Colorado** from drop down list and **enter**. From the **Provider Home** tab, select the link titled **Contact Us (Escalation Contact List & Alpha Prefix Reference List)**.

Any 5-digit numerical physician Current Procedural Terminology (“CPT”) codes, service descriptions, 2-digit modifiers, instructions and/or related guidelines are copyright © 2012 by the American Medical Association (“AMA”). All rights reserved.

This Manual includes CPT codes selected by Anthem. No fee schedules, basic unit values, relative value guides, maximum allowances, conversion factors or scales are included in CPT. The AMA assumes no responsibility for any information contained or not contained in this Manual. The AMA doesn't directly or indirectly practice medicine or dispense medical services.

Please note: Material in this Manual is subject to change. The most up-to-date version is available online. Go to **anthem.com**, select the **Provider** link in top center of the page. Select **Colorado** from drop down list and **enter**. From the **Provider Home** tab, select the link titled [Provider Manual](#).

Legal and Administrative Requirements Overview

[Dispute Resolution and Arbitration](#)

The substantive rights and obligations of Anthem, Providers and Facilities with respect to resolving disputes are set forth in the Anthem Facility Agreement (the “Agreement”) or the Anthem Provider Agreement (the “Agreement”). The following provisions set forth some of the procedures and processes that must be followed during the exercise of the Dispute Resolution and Arbitration Provisions in the Agreement.

A. Cost of Non-binding Mediation

The cost of the non-binding mediation will be shared equally between the parties, except that each party shall bear the cost of its own attorney's fees.

B. Location of the Arbitration

The arbitration hearing will be held in the city and state in which the Anthem office identified in the address block on the signature page to the Agreement is located except to the extent both parties agree in writing to hold the arbitration hearing in some other location.

C. Selection and Replacement of Arbitrator(s)

For disputes equal to or greater than (exclusive of interests, costs or attorneys' fees) the dollar thresholds set forth in Article VII of the Agreement then the panel shall be selected in the following manner. The arbitration panel shall consist of one (1) arbitrator selected by Provider or Facility, one (1) arbitrator selected by Anthem, and one (1) independent arbitrator to be selected and agreed upon by the first two (2) arbitrators. If the arbitrators selected by Provider or Facility and Anthem cannot agree in 30 days on who will serve as the independent arbitrator, then the arbitration administrator identified in Article VII of the Agreement shall appoint the independent arbitrator. In the event that any arbitrator withdraws from or is unable to continue with the arbitration for any reason, a replacement arbitrator shall be selected in the same manner in which the arbitrator who is being replaced was selected.

D. Discovery

The parties recognize that litigation in state and federal courts is costly and burdensome. One of the parties' goals in providing for disputes to be arbitrated instead of litigated is to reduce the costs and burdens associated with resolving disputes. Accordingly, the parties expressly agree that discovery shall be conducted with strict adherence to the rules and procedures established by the mediation or arbitration administrator identified in Article VII of the Agreement, except that the parties will be entitled to serve requests for production of documents and data, which shall be governed by Federal Rules of Civil Procedure 26 and 34.

E. Decision of Arbitrator(s)

The decision of the arbitrator, if a single arbitrator is used, or the majority decision of the arbitrators, if a panel is used, shall be binding. The arbitrator(s) may construe or interpret, but shall not vary or ignore, the provisions of the Agreement and shall be bound by and follow controlling law including, but not limited to, any applicable statute of limitations, which shall not be tolled or modified by the Agreement. If there is a dispute regarding the applicability or enforcement of the class waiver provisions found in section 7.2.3, that dispute shall only be decided by a court of competent jurisdiction and shall not be decided by the arbitrator(s). If the arbitrator(s) awards injunctive relief, the injunctive relief can only be awarded to benefit the individually named claimant. Either party may request a reasoned award or decision, and if

either party makes such a request, the arbitrator(s) shall issue a reasoned award or decision setting forth the factual and legal basis for the decision.

The arbitrator(s) may consider and decide the merits of the dispute or any issue in the dispute on a motion for summary disposition. In ruling on a motion for summary disposition, the arbitrator(s) shall apply the standards applicable to motions for summary judgment under Federal Rule of Civil Procedure 56. The cost of any arbitration proceeding under this section shall be shared equally by the parties to such dispute unless otherwise ordered by the arbitrator(s) in accordance with Federal Rule of Civil Procedure 11; provided, however, that the arbitrator(s) may not require one party to pay all or part of the other party's attorneys' fees. Judgment upon the award rendered by the arbitrator(s) may be confirmed and enforced in any court of competent jurisdiction. Without limiting the foregoing, the parties hereby consent to the jurisdiction of the courts in the State(s) in which Anthem is located and of the United States District Courts sitting in the State(s) in which Anthem is located for confirmation and injunctive, specific enforcement, or other relief in furtherance of the arbitration proceedings or to enforce judgment of the award in such arbitration proceeding.

F. Confidentiality

All statements made, materials generated or exchanged, and conduct occurring during the arbitration process including, but not limited to, materials produced during discovery, arbitration statements filed with the arbitrator(s), and the decision of the arbitrator(s), are confidential and shall not be disclosed in any manner to any person who is not a director, officer, or employee of a party or an arbitrator or used for any purpose outside the arbitration. If either party files an action in federal or state court arising from or relating to a mediation or arbitration, all documents must be filed under seal to ensure that confidentiality is maintained.

Insurance Requirements

A. Providers and Facilities shall, during the term of their Agreements with Anthem, keep in force with insurers having an A.M. Best rating of A minus or better, the following coverage:

2. Professional liability/medical malpractice liability insurance which limits shall comply with all state laws and/or regulations, and shall provide coverage for claims arising out of acts, errors or omissions in the rendering or failure to render those services addressed by this Agreement. In states where there is an applicable statutory cap on malpractice awards, Providers and Facilities shall maintain coverage with limits of not less than the statutory cap.

If this insurance policy is written on a claims-made basis, and said policy terminates and is not replaced with a policy containing a prior acts endorsement, Providers and Facilities agree to furnish and maintain an extended period reporting endorsement ("tail policy") for the term of not less than three (3) years.

3. Workers' Compensation coverage with statutory limits and Employers Liability insurance

4. Commercial general liability insurance for Facilities with limits of not less than \$1,000,000 per occurrence and \$2,000,000 in the aggregate for bodily injury and property damage, including personal injury and contractual liability coverage. (These commercial general liability limits are encouraged for Providers, as well);
- B. Self-Insurance can be in the form of a captive or self-management of a large retention through a trust. A self-insured Provider or Facility shall maintain and provide evidence of the following upon request:
1. Actuarially validated reserve adequacy for incurred Claims, incurred but not reported Claims and future claims based on past experience;
 2. Designated claim third party administrator or appropriately licensed and employed claims professional or attorney;
 3. Designated professional liability or medical malpractice defense firm(s);
 4. Excess insurance/re-insurance above self-insured layer; self-insured retention and insurance combined must meet minimum limit requirements; and
 5. Evidence of surety bond, reserve or line of credit as collateral for the self-insured limit.
- C. Providers and Facilities shall notify Anthem of a reduction in, cancellation of, or lapse in coverage within ten (10) days of such a change. A certificate of insurance shall be provided to Anthem upon request.

Member Rights and Responsibilities

The delivery of quality health care requires cooperation between Covered Individuals, their Providers and Facilities and their health care benefit plans. One of the first steps is for Covered Individuals, Providers and Facilities to understand member rights and responsibilities. Therefore, Anthem has adopted a Members' Rights and Responsibilities statement which can be accessed by going to **anthem.com**. Select the **Provider** link at the top of the landing page (under "Other Anthem Websites" section). Select **Colorado** from the drop down list, and **enter**. Select the **Health & Wellness** tab, then the link titled "[Quality Improvement and Standards](#)". If Covered Individuals need more information or would like to contact us, they are instructed to go to anthem.com and select Customer Support, then Contact Us. Or they can call the Member Services number on their ID card.

Misrouted Protected Health Information (PHI)

Providers and Facilities are required to review all Covered Individual information received from Anthem to ensure no misrouted PHI is included. Misrouted PHI includes information about Covered Individuals that a Provider or Facility is not currently treating. PHI can be misrouted to Providers and Facilities by mail, fax, email, or electronic remittance. Providers and Facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are Providers or Facilities permitted to misuse or re-disclose misrouted PHI. If Providers or Facilities cannot destroy or safeguard misrouted PHI, Providers and Facilities must contact your Provider Engagement and Contracting representative to report receipt of misrouted PHI.

Open Practice

Provider shall give Plan sixty (60) days prior written notice when Provider no longer accepts new patients.

Release of Information/Confidentiality

Members should expect that Anthem and its Providers and Facilities will protect their right to privacy in all care settings.

All records relating to the health care of Anthem members or containing protected health information (“PHI”) as defined by HIPAA, including PHI stored in written, electronic or oral format throughout the Anthem organization, are completely confidential. Confidential information is maintained behind locked doors with key card access and in locked storage (where appropriate) except during business hours. Providers may request a copy of Anthem’s confidentiality policy at any time. Disclosure of information relating to substance and alcohol abuse is subject to federal regulations governing such disclosure. Members may request to review their medical record data. Data will not be released to employers in a member-identifiable format.

Anthem will not release any confidential, member-identifiable information outside the organization, except as allowed by applicable regulations and federal and state laws, without obtaining the member’s written permission on a special consent authorization form.

Anthem has legal authority to access members’ medical records for the purpose of health care operations functions, including quality management and UM purposes. At the time of contracting, providers agree to release medical records for purposes of quality management and UM. The medical information releases entitle Anthem to access to medical records information at the PCP’s office and specialist’s office, and hospital inpatient records, outpatient records and records for other ancillary services provided to members for purposes of quality management and UM. Anthem may also request copies of medical records. Members participating in studies will be asked to sign a special consent authorization form, prior to release of their data, when the data is to be used for purposes outside normal health care operations or when release of the data is allowed and/or required by state or federal law.

Risk Adjustments

Compliance with Federal Laws, Audits and Record Retention Requirements

Medical records and other health and enrollment information of Covered Individuals must be handled under established procedures that:

- Safeguard the privacy of any information that identifies a particular Covered Individual;
- Maintain such records and information in a manner that is accurate and timely; and
- Identify when and to whom Covered Individual information may be disclosed.

In addition to the obligation to safeguard the privacy of any information that identifies a Covered Individual, Anthem, Providers and Facilities are obligated to abide by all Federal and state laws regarding confidentiality and disclosure for medical health records (including mental health records) and enrollee information.

Encounter Data for Risk Adjustment Purposes

Commercial Risk Adjustment and Data Submission: Risk adjustment is the process used by Health and Human Services (HHS) to adjust the payment made to the Federal Exchange plans based on the health status of the Exchange Covered Individuals. Risk adjustment was implemented to pay health plans participating in Exchanges more accurately for the predicted health cost expenditures of Covered Individuals by adjusting payments based on demographics (age and gender) as well as health status. Anthem, as an Exchange Participating Organization (EPO) defined by HHS, is required to submit diagnosis data collected from encounter and claim data to HHS for purposes of risk adjustment. Because HHS requires that EPOs submit “all ICD9 codes for each beneficiary”, Anthem also collects diagnosis data from the Covered Individuals’ medical records created and maintained by the Provider or Facility.

Under the HHS risk adjustment model, the EPO is permitted to submit diagnosis data from inpatient hospital, outpatient hospital and physician encounters only.

RADV Audits

As part of the risk adjustment process, HHS will perform a risk adjustment data validation (RADV) audit in order to validate the Exchange Covered Individuals’ diagnosis data that was previously submitted by EPOs. These audits are typically performed once a year. If the EPO is selected by HHS to participate in a RADV audit, the EPO and the Providers or Facilities that treated the Exchange Covered Individuals included in the audit will be required to submit medical records to validate the diagnosis data previously submitted.

ICD-9 CM Codes

HHS requires that physicians currently use the ICD-9 CM Codes (ICD-9 Codes) or successor codes and coding practices for Exchange product business. In all cases, the medical record documentation must support the ICD-9 Codes or successor codes selected and substantiate that proper coding guidelines were followed by the Provider or Facility. For example, in accordance with the guidelines, it is important for physicians to code all conditions that co-exist at the time of an encounter and that require or affect patient care or treatment. In addition, coding guidelines require that the Provider or Facility code to the highest level of specificity which includes fully documenting the patient’s diagnosis.

Medical Record Documentation Requirements

Medical records significantly impact risk adjustment because:

- They are a valuable source of diagnosis data;
- They dictate what ICD-9 Code or successor code is assigned; and

- They are used to validate diagnosis data that was previously provided to HHS by the Exchange participating organizations.

Because of this, the Provider and Facility play an extremely important role in ensuring that the best documentation practices are established.

HHS record documentation requirements include:

- Patient's name and date of birth should appear on all pages of record.
- Patient's condition(s) should be clearly documented in record.
- The documentation must show that the condition was monitored, evaluated, assessed/addressed or treated (MEAT).
- The documentation describing the condition and MEAT must be legible.
- The documentation must be clear, concise, complete and specific.
- When using abbreviations, use standard and appropriate abbreviations. Because some abbreviations have different meanings, use the abbreviation that is appropriate for the context in which it is being used.
- Physician's signature, credentials and date must appear on record and must be legible.

Directory of Services/Provider Resource Information

[Provider Contact Information](#)

We provide two main documents for contact information for our providers:

1. **Alpha Prefix Reference List** – one page list provides customer service phone numbers, address information for claims, adjustments, appeals, and correspondence, as well as Authorization phone number information.
 - This list is split out by member type, as identified by the member's three (3) character alpha prefix in front of their ID number.
 - This will help ensure you can contact the appropriate customer service, or authorization unit the first time to avoid unnecessary transfers.
2. **Escalation Contact List** – This document outlines our escalation process and includes phone numbers and email addresses for our team leads and managers in many of our provider servicing areas. It includes contact information for the following areas:
 - Local Provider Customer Service
 - Federal Employee Program Provider Customer Service
 - BlueCard Provider Customer Service
 - Pre-certification/Authorizations
 - ProviderAccess Support Team
 - Electronic Data Interchange ("EDI") Solutions Team
 - Colorado Medical Directors Back line
 - Provider Engagement and Contracting:

- Provider Relations
- Provider Contracting
- Provider Education/Communication

Our contact information is also posted online. Go to **anthem.com**, select the **Provider** link in top center of the page. Select **Colorado** from drop down list and **enter**. From the **Provider Home** tab, select the link titled **Contact Us ([Escalation Contact List & Alpha Prefix Reference List](#))**.

[Provider Communications](#)

Our provider communications are primarily sent via email or fax. All of our communications are also posted online at anthem.com.

- Go to **anthem.com**, select the **Provider** link in top center of the page. Select **Colorado** from drop down list and **enter**. From the **Provider Home** tab, select the link titled **Provider Communications and Education**, then select [Provider Communications](#).
- To register to receive our communications, please fill out our Anthem Network eUpdate form – **It's fast, efficient and NO COST!** To register, simply:
 - Go to **anthem.com**, select the **Provider** link in top center of the page. Select **Colorado** from drop down list and **enter**. From the **Provider Home** tab, select the link titled "[Anthem Network eUpdate \(registration form\)](#)."
 - Complete and submit the simple registration form for immediate registration.

[Provider Newsletter](#)

Provider Newsletter, Network Update – We distribute a monthly newsletter to our providers that goes out on the first Friday of every month.

- Our Provider Newsletters are also posted online. Go to **anthem.com**, select the **Provider** link in top center of the page. Select **Colorado** from drop down list and **enter**. From the **Provider Home** tab, select the link titled **Provider Communications and Education**, then [Network Update \(Provider Newsletter\)](#).
- To register to receive our newsletters, please fill out our Anthem Network eUpdate form – **It's fast, efficient and NO COST!** To register, simply:
 - Go to **anthem.com**, select the **Provider** link in top center of the page. Select **Colorado** from drop down list and **enter**. From the **Provider Home** tab, select the link titled "[Anthem Network eUpdate \(registration form\)](#)."
 - Complete and submit the simple registration form for immediate registration.

[Provider Seminars](#)

Provider seminars are conducted twice a year – spring and fall, and the information is also posted online.

- Go to **anthem.com**, select the **Provider** link in top center of the page. Select **Colorado** from drop down list and **enter**. From the **Provider Home** tab, select the link titled [Provider Seminars](#).

[Provider In-Service](#)

Provider In-Services, one-on-one meetings – Providers and Facilities can request an in-service or one-on-one meeting with his/her Provider Contract and/or Provider Relations representative. If you would like to request a visit, or training on a specific topic, please feel free to contact your Provider Contracting and/or Provider Relations representative to schedule a meeting. (Please see the [Escalation Contact List](#) for direct contact information).

[Provider Toolkit](#)

We have created a toolkit online for providers to access with helpful references, quick links to provider information, as well as contact information, and education tools including:

- Anthem 101 for Colorado Providers
- Membership Health Plan ID Card samples
- Provider EOB/RA Frequently Asked Questions
- View Policies
- Quick Links to:
 - Provider Manual
 - Provider newsletter, *Network Update*
 - Provider Communications
 - ProviderAccess Demo
- Contact Information:
 - Alpha Prefix Reference List
 - Escalation Contact List

Our Provider Toolkit information is posted online. Go to **anthem.com**, select the **Provider** link in top center of the page. Select **Colorado** from drop down list and **enter**. From the **Provider Home** tab, select the link titled **Provider Communications and Education**, then [Provider Toolkit](#).

[Online Provider Directory](#)

For a complete listing of Providers and Facilities, please check our online directory. Go to **anthem.com**, select the **Provider** link in top center of the page. Select **Colorado** from drop down list and **enter**. From the **Provider Home** tab, select the **enter** button from the blue box on the left side of page titled "[Find a Doctor](#)".

Note: laboratories are listed under Provider Type of "Hospitals, Facilities, Services, and Equipment" and pathologists are listed under Provider Type of "Other Health Professionals".

[Primary Care Physician Change Request](#)

HMO Colorado Covered Individuals must select a primary care physician (“PCP”) of their choice from the HMO Colorado network. Customer service grants and processes PCP change requests.

Procedure

- A Covered Individual can request to change PCPs by calling HMO Colorado’s customer service department.
- If the Covered Individual indicates a potential quality issue or grievance and complaint at the time of the change request, customer service will ask the Covered Individual to submit additional information in writing about the potential issue. If we receive written notice of a potential quality issue or grievance and complaint, we’ll send it to the grievance and complaint department for research. An associate from that department will communicate HMO Colorado’s resolution/action related to the potential issue to the Covered Individual and to the provider. The grievance and complaint department maintains a copy of this correspondence in its confidential files.
- This process may take at least thirty (30) calendar days for research and processing of a potential quality issue or grievance and complaint that requires investigation.
- Customer service will process the Covered Individual’s PCP change request and, if approved, the effective date of the change.

[Member Notification Regarding Provider Termination](#)

When a Provider or Facility’s contract is terminated, Anthem will notify members as required by C.R.S. 10-16-705 (7) and related regulations, as amended from time to time.

[Provider File and Online Directory Management](#)

Our online provider directory lists physicians, hospitals and other health care professionals in our networks (see Provider Online Directory section). The provider directory provides the most up-to-date information available about Providers and Facilities.

We invite you to check your own listing in our online provider directory to ensure the information we provide to our members about you is accurate. If any of your information is incorrect, please complete the [Provider Maintenance Form](#).

[Provider Maintenance Form](#)

The online Provider Maintenance Form replaces the previous Provider Change Form and should be used by Colorado physicians, providers and professionals to submit demographic or other practice changes to Anthem. Examples include but are not limited to: practice or provider name change, address change, tax ID change, opening

or closing a practice location. (Note: Do not use this form to request participation for a new provider or practitioner. Use the New Provider Application Form.)

All requests must be received 30 days prior to change/update. Any request received with less than 30 days notice may be assigned a future effective date. Contractual guidelines may supersede effective date request. Please provide 90 days notice of termination from our network.

Benefits of online Provider Maintenance Form:

- Automated form will allow you to enter all of your information online, press submit, and send directly to Anthem for processing.
- You will receive automatic confirmation of receipt.
- Helping to avoid unnecessary delays due to incomplete requests, the online form edits for any required fields before you can submit.
- We are anticipating shorter turnaround times once this online form is implemented.

How to access the Provider Maintenance Form:

Go to **anthem.com**, select the **Provider** link in upper left corner. Select **Colorado** from drop down list and **enter**. From the **Provider Home** tab, select the link titled “**Download Commonly Requested Forms**”, then “**[Provider Maintenance Form \(formerly known as Provider Change Form\)](#)**”.

[New Provider Application Form](#)

The New Provider Application Form is available online and replaces the Provider Data Sheet and should be used by Colorado physicians, providers and professionals to apply for participation with Anthem.

Benefits of online New Provider Application Form:

- Automated form will allow you to enter all of your information online, press submit, and send directly to our Provider Engagement and Contracting (PE&C) system for processing.
- You will receive automatic confirmation of receipt.
- Helping to avoid unnecessary delays due to incomplete requests, the online form edits for any required fields before you can submit.
- If provider is already registered with CAQH, new form requires fewer fields to be entered.
- You may also notice even shorter turnaround times once this online form is implemented.
- Upon credentialing approval, notification and effective date will be sent electronically back to submitter of the request.

How to access the New Provider Application Form:

Go to **anthem.com**, select the **Provider** link in upper left corner. Select **Colorado** from drop down list and **enter**. From the **Join our Networks** tab, select the link titled “**Medical Professional Providers and Ancillary Providers**”, then “[New Provider Application Form](#)”.

[CAQH ID Number Request Form](#)

We’ve developed a form to allow providers who require credentialing to request a CAQH ID number which is an essential piece of the credentialing application.

Physicians and practitioners who must be credentialed for our networks and who do not yet have a CAQH ID number should first complete our online CAQH ID Number Request Form. Once you receive the CAQH ID number, you can complete the New Provider Application Form.

Benefits of the online CAQH ID Number Request Form:

- Automated form will allow you to enter all of your information online, press submit, and send directly to our Provider Engagement and Contracting (PE&C) team for processing.
- You will receive automatic confirmation of receipt.
- Online form edits for any required fields before you can submit, helping to avoid unnecessary delays due to incomplete requests.
- You may also notice even shorter turnaround times once this online form is implemented.

How to access the CAQH ID Number Request Form:

Go to **anthem.com**, select the **Provider** link in upper left corner. Select **Colorado** from drop down list and **enter**. From the new **Join our Networks** tab, select the link titled “**Medical Professional Providers and Ancillary Providers**”, select the link titled “[CAQH ID Number Request Form](#)”.

Provider Portal Connectivity Options

[Provider portal options for Providers and Facilities](#)

ProviderAccess – Anthem’s secure provider portal:

- Available for Anthem membership only
- Includes Local Plan, BlueCard, and Federal Employee Program (FEP) members

Availity Web Portal – multi-payer portal:

- Available for Anthem membership

- Includes Local Plan, BlueCard, and Federal Employee Program (FEP) members
- Access other payers in Colorado along with Anthem information on one portal

[ProviderAccess®](#)

What is ProviderAccess®?

Anthem's ProviderAccess functions provide helpful online tools that let providers get information in a secure environment without having to call our customer service units. Our goal in offering these online options is to help make it easy for you to do business with us.

Some of the functionality on ProviderAccess has moved to being available exclusively through Availity Web Portal, our multi-payer portal solution. As functionality is shutdown on ProviderAccess, Providers will be notified prior to any type of change.

- **The following functions have been shut down on ProviderAccess and are only available via Availity's Web Portal:**
 - Eligibility and Benefits Inquiry – March 14, 2014
 - Claims Status Inquiry – March 14, 2014
 - Medical Referral and Pre-Authorization Inquiry – August 15, 2014
- **Functionality that remains on ProviderAccess:**
 - Remittance Advice Inquiry
 - Contracted Pricing Tool
 - Clear Claim Connection
 - Reimbursement Policies
 - Active User Report

Our ProviderAccess online services are available at **anthem.com**:

How to Get Started with ProviderAccess

1. Go to **anthem.com**.
2. Click the **Providers** link in the top center of the page.
3. Select **Colorado** from the state drop-down box, and **Enter**.
4. From the **ProviderAccess Login** tout (blue box on left side of page), click on the link titled "[Register Now](#)".
5. Complete the registration online. You will receive email confirmation usually within 1 business week.

For questions or issues during the registration process, please email provideraccesswest@anthem.com.

Overview Tab

- Quick links to helpful resources/documents
 - Provider News
 - Provider Manual
 - Download Commonly Requested forms
 - View Policies (Reimbursement Policies, Medical Policies, Clinical UM Guidelines)

Claims Tab (*for Local, FEP and BlueCard members*)

- Claim reports
 - Run your own claims reports for all claims paid, processed or denied for Local and BlueCard claims
- Remittance Advice Inquiry –
 - View and save your remittances online anytime - 24/7.
- Clear Claim Connection
 - A tool for evaluating clinical coding information supplied by McKesson, Inc. It allows providers to view clinically based information along with documented source information for approximately 2 million edits also incorporating editing for some of our reimbursement policies.
- Contracted Pricing
 - Professional contracted pricing tool, allows providers to enter CPT codes and see contracted pricing by line of business. (Does not include site of service, only non-facility pricing).

ProviderAccess Account Administrator Change Form

The ***ProviderAccess Account Administrator Change Form*** can be utilized to request a variety of updates including:

- Changing your Account Administrator
- Updating your account TAX ID number
- Updating your NPI number
- Adding an alternate TAX ID

To request any of these changes for your organization, simply complete the change form by tabbing and following the instructions listed on the form.

If you are changing your Account Administrator, ***ProviderAccess Account Administrator Change Form*** must be submitted with a signed ***ProviderAccess Account Agreement*** (original signature is required). Both completed forms must be emailed or faxed to Anthem for processing (email/fax directions included on forms).

You can locate both forms online at **anthem.com**. Select the **Provider** link in top center of the page. Select **Colorado** from drop down list and **enter**. From the **Provider Home** tab, select the link titled **Download Commonly Requested Forms**, and then:

- [ProviderAccess Account Administrator Change Form](#)
- [ProviderAccess Account Agreement](#)

ProviderAccess Support

Once registered for ProviderAccess, we have dedicated associates in our ProviderAccess Support Team who provide technical support for utilizing portal tools, password resets, or issues that arise while accessing the portal.

For ProviderAccess questions or issues, please call the ProviderAccess Support Team at **866-302-1384**.

[Availity Web Portal](#)

Availity Web Portal services offered to Anthem providers

Anthem is pleased to announce the expansion of our provider portal services through Availity Web Portal, a multi-payer web portal. Using a single sign-on, you are now able to access multiple payers to check eligibility, claims and many other services through Availity.

Anthem services available at www.availity.com:

- **Member eligibility and benefits inquiry** – includes local Anthem plan, BlueCard/out-of-area, and FEP members
- **Claim status inquiry** – includes local Anthem plan, BlueCard/out-of-area, and FEP members
- **Claim submission** – submit a single, electronic claim
- **Secure messaging*** – send a question to clarify the status of a claim or to get additional information on claim (including local Anthem plan, BlueCard/out-of-area, and FEP member claims)
- **Link to AIM Specialty Health® (AIM)*** – Online pre-certification for Imaging and Specialty Drug Requests through AIM.
- **Patient care summary** – real-time, consolidated view of a member's medical history based on claims information across multiple providers
- **Care reminders** – clinical alerts on patients' care gaps and medication compliance indicators (when the member's employer is participating and when there is a gap in care).
- **Certificate of Coverage** – view a local plan member's certificate of coverage, when available
- **Interactive Care Reviewer** – secure, online provider precertification tool

- **Easy ‘single sign-on’ to ProviderAccess*** – Access a link out to ProviderAccess (for functionality that will remain on ProviderAccess at this point in time) through *My Payer Portals* without having to login a second time

NOTE: *You first must be registered for ProviderAccess to have this functionality.

Advantages of using Availity Web Portal

Benefits include:

- **No charge** – Health plan transactions are available at no charge to providers, while at the same time saving time and money.
- **Accessibility** – Availity Web Portal functions are available 24 hours a day from any computer with Internet access.
- **Standard responses** – Availity Web Portal returns responses from multiple payers in the same format and screen layout, providing users with a consistent look and feel.
- **Commercial and Government Payers** – Access to data from Anthem, Medicare, Medicaid and other commercial carriers. (See www.availity.com for a full list of payers)
- **Compliance** – Availity Web Portal is compliant with all Health Insurance Portability and Accountability Act (HIPAA) regulations.

Availity Registration Information

- Go to www.availity.com.
- Click on “**Get Started**” under Register now for the Availity Web Portal, and then complete the online registration wizard.
- The administrator will receive an e-mail from Availity with a temporary password and next steps.
- If you need further assistance with Availity, please contact Availity Client Services at 1-800-AVAILITY (282-4548).
- Please note that it may take up to five days to complete registration.

Anthem Services Registration

There are certain value-added features for Anthem on the Availity Web Portal, such as:

- **Secure messaging*** – send a question to clarify the status of a claim or to get additional information on claim (including local Anthem plan, BlueCard/out-of-area, and FEP member claims)
- **Link to AIM Specialty Health® (AIM)*** – Online pre-certification for Imaging and Specialty Drug Requests through AIM.
- **Provider Portal – Easy ‘single sign-on’ to ProviderAccess*** – Access a link out to ProviderAccess (for functionality that will remain on ProviderAccess at this point in time) through *My Payer Portals* without having to login a second time

Each of these features are only available if the User also has a ProviderAccess User ID, and the Primary Access Administrator (PAA), completes the Anthem Services Registration by follow these steps:

1. In the Availity portal, click **My Account | Anthem Services Registration**. If prompted, select your organization.
2. In the **Display** field, click **Non-Registered Users**.
3. In the table that displays, locate each user you want to register and type the user's valid ProviderAccess user ID in the **Health Plan User ID** field. Then click **Register** at the bottom of the page to access the User(s) Registered page.

Note: If a user's name is not listed, you must first add the user in Availity. Click **Account Administration | Add User**. The user's first and last names in Availity must exactly match those in the Anthem Blue Cross system. If the name is incorrect in Availity, click **Account Administration | Maintain User** to correct the user's name.

4. When the registration is successful, users can begin using the services the next time they log in to the Availity Web Portal. If an error message displays, the registration or change was not successful for that user. Follow instructions on the page to reconcile the error.

Note: By default, users are registered for all available services. If you want to remove a user's access to a specific service, see the following section "Changing Access for Registered Users."

Changing Access for Registered Users

If necessary, you can also change or remove a user's access to Anthem services on Availity. On the Anthem Service Registration page, click **Registered Users**, add or remove services as needed, and then click **Save Changes**.

1. In the **Display** field, click **Registered Users**.
2. To enable the **Save Changes** button, make changes to one or more selections in the **Services** column.
3. Click **Save Changes**.

If you selected a new service for a user, but it does not display in the **Services** column on the Changes Saved page, the user may not have the business function within Anthem's ProviderAccess. Please check your user's access on ProviderAccess. If an error message displays for a user in the list, the registration or change was not successful; verify the information you entered and try again. If the list is blank, you clicked the **Save Changes** button without making any changes on the Registered Users page.

Note: If the error persists, note the transaction ID listed at the bottom of the page and call Availity Client Services at 1.800.AVAILITY (282.4548).

Free Training

Once you log into the Availity Main Menu page, you'll have access to many resources to help jumpstart your learning, including free live training, on-demand training, frequently asked questions, and comprehensive help topics. To view current training resources, click **Free Training** at the top of any page in the Availity Web Portal or click <http://www.rsvpbook.com/AvailityWest> to find a current schedule of FREE Availity workshops and webinars.

Availity, an independent company, provides claims management services for Anthem Blue Cross and Blue Shield.

Eligibility

Member Health Plan ID Cards

Health Benefit Plans, amendments and coverage notices are available to all Anthem group and non-group subscribers and to all HMO Colorado group subscribers at anthem.com. Subscribers may also request a printed copy of their Health Benefit Plan by mailing the postage-paid postcard included with their health plan ID card(s), or by calling the customer service number on their ID card. The Health Benefit Plan, amendments and coverage notices explain the type of coverage and benefits available to the member, as well as limitations and exclusions.

Anthem mails health plan ID cards to all Anthem and HMO Colorado groups (i.e., to the employer or to the group subscribers) and to all non-group subscribers. Some local Colorado member health plan ID cards list an issue date and an effective date. The card issue date is the date the card was printed. The effective date is the date the benefits under the member's Health Benefit Plan were available to the member. With each visit, please ask members for the most current copy of their health plan ID card.

Samples of our Member Health Plan ID Cards are available in our Provider Toolkit online at anthem.com. Go to **anthem.com**, select the **Provider** link in top center of the page. Select **Colorado** from drop down list and **enter**. From the **Provider Home** tab, select the link titled **Provider Communications and Education**, then **Provider Toolkit**, and "[Membership Health Plan ID Card Samples](#)".

Verifying Member Coverage

Member health plan ID cards include information about verifying member eligibility. Possession of a health plan ID card does not guarantee that the person is an eligible member. If a member does not have a health plan ID card, please contact Anthem customer service or BlueCard eligibility at the phone numbers in the [Alpha Prefix Reference List](#).

Claims Submission/Claim Action Request Procedures

Claims Requirements

A claim is the uniform bill form or electronic submission form in the format used by Anthem and submitted for payment by a provider for Covered Services rendered to an Anthem member. Anthem only accepts one member and one provider per claim.

We encourage you to submit claims electronically. Electronic claims submission is fast, accurate and reliable. Electronic claims may be submitted twenty four (24) hours a day, seven (7) days a week. If complete information is provided, they will typically be processed seven to 10 days faster than paper claims. Please see the Electronic Claims Submission subsection in this section of the Manual for more information. Also visit our web site at anthem.com/edi then select your state. Here you will find information on EDI transactions.

If submitting claims electronically is not a viable alternative, claims must be submitted on a CMS-1500 claim form for professional and other non-facility services and on an UB-04 CMS-1450 claim form for services provided in a facility. To be considered a clean claim, the following information is **MANDATORY**, as defined by applicable law, for each claim:

- A. The following fields of the CMS-1500 claim form must be completed before a claim can be considered a “clean claim:”
 - 1. Field 1: Type of insurance coverage
 - 2. Field 1a: Insured ID number
 - 3. Field 2: Patient's name
 - 4. Field 3: Patient's birth date and sex
 - 5. Field 4: Insured's name
 - 6. Field 5: Patient's address
 - 7. Field 6: Patient's relationship to insured
 - 8. Field 7: Insured's address (if same as patient address; can indicate “same”)
 - 9. Field 8: Patient's status (required only if patient is a dependent)
 - 10. Field 9 (a-d): Other insurance information (only if 11d is answered in “yes”)
 - 11. Field 10 (a-c): Relation of condition to: employment, auto accident or other accident;
 - 12. Field 11: Insured's policy, group or FECA number
 - 13. Field 11c: Insurance plan or program name
 - 14. Field 11d: Other insurance indicator
 - 15. Field 12: Information release (“signature on file” is acceptable)
 - 16. Field 13: Assignment of benefits (“signature on file” is acceptable)
 - 17. Field 14: Date of onset of illness or condition
 - 18. Field 17: Name of referring physician (if applicable)
 - 19. Field 21: Diagnosis code
 - 20. Field 23: Prior authorization number (if any)
 - 21. Field 24: A, B, D, E, F, G) Details about services provided (C, H Medicaid only)
 - 22. Field 24 I, J: Non-NPI provider information

- 23. Field 25: Federal tax ID number
- 24. Field 28: Total charge
- 25. Field 31: Signature of provider including degrees or credentials (provider name sufficient)
- 26. Field 32: Address of facility where services were rendered
- 27. Field 32a: National Provider Identifier (NPI);
- 28. Field 32b: Non-NPI (QUAL ID), as applicable
- 29. Field 33: Provider's billing information and phone number
- 30. Field 33a: National Provider Identifier (NPI); and
- 31. Field 33b: Non-NPI (QUAL ID), as applicable

B. The following fields of the UB-04 CMS-1450 claim form must be completed for a claim to be considered a "clean claim:"

- 1. Field 1: Servicing provider's name, address, and telephone number
- 2. Field 3: Patient's control or medical record number
- 3. Field 4: Type of bill code
- 4. Field 5: Provider's federal tax ID number
- 5. Field 6: Statement Covers Period From/Through
- 6. Field 8: Patient's name
- 7. Field 9: Patient's address
- 8. Field 10: Patient's birth date
- 9. Field 11: Patient's sex
- 10. Field 12: Date of admission
- 11. Field 13: Hour of admission
- 12. Field 14: Type of admission/visit
- 13. Field 15: Admission source code
- 14. Field 16: Discharge hour (for maternity only)
- 15. Field 17: Patient discharge status
- 16. Fields 31-36: Occurrence information (accidents only)
- 17. Field 38: Responsible party's name and address (if same as patient can indicate "same")
- 18. Fields 39-41: Value codes and amounts
- 19. Field 42: Revenue code
- 20. Field 43: Revenue descriptions
- 21. Field 44: HCPCS/Rates/HIPPS Rate Codes
- 22. Field 45: Service/creation date (for outpatient services only)
- 23. Field 46: Service units
- 24. Field 47: Total charges
- 25. Field 50: Payer(s) information
- 26. Field 52: Information release
- 27. Field 53: Assignment of benefits
- 28. Field 56: PI
- 29. Field 58: Insured's name
- 30. Field 59: Relationship of patient to insured
- 31. Field 60: Insured's unique ID number
- 32. Field 62: Insurance group number(s) (only if group coverage)
- 33. Field 63: Prior authorization or treatment authorization number (if any)
- 34. Fields 65: Employer information (for Workers' compensation claims only)
- 35. Field 66: ICD Version Indicator
- 36. Field 67: Principal diagnosis code

- 37. Field 69: Admitting diagnosis code (inpatient only)
- 38. Field 74: Principal procedure code and date (when applicable); and
- 39. Field 76: Attending physician's name and ID (NPI or QUAL ID)

Providers must bill with current CPT or Healthcare Common Procedure Coding System Level II (HCPCS) codes. Codes that have been deleted from CPT or HCPCS are not recognized. When a miscellaneous procedure code is billed or a code is used for a service not described in CPT or HCPCS, supportive documentation must be submitted with the claim.

Only submit claims **after** service is rendered. Claims submitted without the above **mandatory** information are not accepted and will be returned to the provider. In those cases, please fully complete and return the **corrected** claim with the Return to Provider Form within thirty (30) calendar days for processing.

Claims **denied** for incorrect or incomplete information must be resubmitted (with corrected information) on a Claim Action Request Form ("CARF"). Please resubmit the claim with a copy of the Anthem EOB/RA showing the claim denial. Return the claim for processing within thirty (30) calendar days of the denial notice. When submitting corrected information on a **full, partially paid, or denied** claim, an **adjustment** must be requested on a Claim Action Request Form, rather than submitting a new claim. (It's recommended that you submit a corrected claim with the CARF). When an **unpaid** claim is returned to you with a cover letter stating that additional information is required for processing, please resubmit the corrected claim requested information (as appropriate) with a copy of the cover letter and a completed Claim Action Request Form. Return the corrected claim or requested information for processing within thirty (30) calendar days of the Anthem letter date. Please see the Claim Action Request Procedures section of this Manual for more information.

[Updated CMS 1500 claim form version 02/12](#)

In June 2013, the National Uniform Claim Committee (NUCC) announced the approval of an updated 1500 Claim Form (version 02/12) that accommodates reporting needs for ICD-10 and aligns with requirements in the Accredited Standards Committee X12 (ASC X12) Health Care Claim: Professional (837P) Version 5010 Technical Report Type 3.

Anthem began accepting the updated 1500 Claim Form version 02/12 starting on January 6, 2014. Please follow the guidelines set forth by the NUCC for completing the new claim form, or your claim may be rejected. For more information about the revised 1500 Claim Form, please visit the [National Uniform Claim Committee website](#), which provides helpful resources such as a [list of changes between the 08/05 and 02/12 claim versions](#) and the [1500 Instruction Manual](#).

Please note that the NUCC's transition timeline for use of the 1500 Claim Form version 08/05 includes a dual submission period from January 6, 2014 – March 31, 2014. Effective April 1, 2014, paper claims should be submitted using only the revised 1500 Claim Form version 02/12. *1500 Claim Form version 02/12.*

Additionally, effective March 15, 2014, Anthem will return **incomplete** paper claims submitted on professional provider CMS 1500 Forms (either 08/05 or 02/12 versions) and institutional provider UB-04 Forms. Providers should ensure that paper claims are complete and follow data element usage, required fields, and valid code sets as defined in the National Uniform Claim Committee CMS-1500 Health Insurance Claim Form Reference Instruction Manual and the National Uniform Billing Committee Official UB-04 Data Specifications Manual.

The following chart outlines instructions for the CMS-1500 Form:

Field	Locator	Instructions
Member ID Number	1a	Enter valid ID numbers exactly as they appear on members' ID cards, including the alpha prefix. For members enrolled in the Federal Employee Program (FEP), use R plus eight numeric digits.
Patient's Name (Last Name, First Name, and Middle Initial)	2	Insert name exactly as it appears on the ID card.
Health Plan Policy owner	4	Name of health plan policy owner (Insured) who is responsible for the policy
Date of Current Illness, Injury, Pregnancy	14- new form	The date and accompanying Qualifier (431 or 484)
Other Date	15- new form	The date and accompanying Qualifier (090, 091, 304, 439, 444, 453, 454, 455, or 471)
Diagnosis Codes	21- new form	Diagnosis codes in consecutive order- A, B, C, D, E to L.
Federal Tax ID Number	25	Indicate if Social Security # or Employer ID #
NPI Number	33A & 24J	NPI of rendering (billing) provider
Total line charge	24F	Enter total amount for line of service. This is NOT the Medicare allowed amount
Diagnosis Pointers	24E- new form	Pointers with Alpha characters
Accurate total charge	28	Line charges must add up to correct total charge

The following chart outlines instructions for the UB-04 Form:

Field	Locator	Instructions
Member ID Number	60	Enter valid ID numbers exactly as they appear on members' ID cards, including the alpha prefix. For FEP members, use R plus eight numeric digits.

Patient's Name (Last Name, First Name, and Middle Initial)	08	Enter patient's first and last name as appropriate
Patient Date of Birth	10	Enter Patients Date of Birth
Insured's Name	58	Identifies name of health plan policy owner (Insured) who is responsible for the policy
Federal Tax ID Number	5	No Special Characters and 9 digits
Patient Admission Type	14	Enter valid patient admission type.
Admission SRC	15	Enter valid patient admission SRC, for Inpatient and Outpatient.
Status	17	Enter valid patient Status, for Inpatient and Outpatient.
Total line charge	47	Enter total amount for line of service. This is NOT the Medicare allowed amount
Accurate Total Charge	47 (line 23)	Check line charges to ensure they add up to correct total charge
Description	43	Enter any description verbiage, if appropriate, in the description field on facility claims
NPI Number	56	Enter accurate 10-digit National Provider Identifier number
Admitting Diagnosis	69	Enter an admitting diagnosis if required for "type of bill" as indicated in the NUBC manual
Value or Monetary Amount	39-41	Submit a value code with its associated value amount (value or monetary amount) if needed
POA Indicators	67	Include valid present on admission (POA) indicators as appropriate
Patient Reason for Visit	70	Required on Outpatient

Facilities must ensure all UB-04 fields are correct

Some facilities submit paper claims to Anthem with information missing from fields 39, 40 and 41. **As of March 15, 2014, paper claims with missing information, illegible information, and/or incorrect amounts will be returned.**

The following is a quick overview of the most common errors on fields 39, 40 and 41 when Medicare is primary and Anthem is secondary:

- Value codes are missing. Value codes A1, B1, C1 are deductibles. Value codes 09, 11, A2, B2 and C2 are coinsurance. Value code 06 is blood deductible.
- The member deductible is missing or does not match the Explanation of Medicare Benefits (EOMB). If there is a deductible amount indicated on the

primary payer's remittance advice, the UB-04 must include the member's deductible (A1, B1 or C1 value code) and amount.

- The coinsurance amount is missing. If there is coinsurance on the primary payer's remittance advice, the UB-04 must include the coinsurance amount (09, 11, A2, B2 or C2 value code).
- Blood deductible is not noted. If there is blood deductible on the payer's remittance advice, the value code 06 must be on the claim along with the amount.
- There are errors in listing multiple value codes. If more than one value code is submitted on lines a – d, please fill in fields 39a, 40a or 41a before populating 39b, 40b, or 41b.

Helpful hints for all paper claims:

- Check the printing of your claims from time to time to ensure proper alignment and that characters are easy to read.
- Ensure all characters are located inside the fields and do not "lie" on the lines or extend beyond the appropriate field. Claims will be returned if we are unable to clearly identify or read the data within a given box/field.
- In addition, please follow these guidelines when the following circumstances apply:
 - When submitting a multiple-page claim, the word "continued" should be noted in the total charge field on each page, with the actual total charge inserted on the LAST page of the claim.
 - When submitting a multiple-page claim, do not staple over any information, as this can make the information on the claim illegible when the staple is removed.

Pass Through Billing

All participating Anthem providers (or their employees) rendering services to Anthem's Covered Individuals are required to bill Anthem directly for that service(s).

Note: an employee of a provider may be a: physician assistant, surgical assistant, advanced practice nurse, clinical nurse specialist, certified nurse midwife, or physical therapist, who is under the direct supervision of the ordering provider and the service is billed by the ordering provider. An employee is a person that receives a W-2 (as opposed to a 1099) from the participating provider, and does not have their own provider or NPI number.

Examples of pass-through billing include but are not limited to:

- A. Laboratory Services - providers should only bill for the component of the services they perform: technical, professional, or both.
- B. **PAP Smear with Evaluation and Management (E/M) code:** Pap smear lab codes are not eligible for separate reimbursement when reported with E/M Codes. In most cases when a family physician, internist or obstetrician/gynecologist submits a

cytopathology/pap smear code, they are not the physicians preparing and/or interpreting the Pap smear. Instead, they are the physicians who obtained the specimen. **The pathologist preparing and interpreting the cytopathology/pap smear must bill for this service separately.**

- In order to bill for Pap smear codes such as CPT codes 88142 through 88154, 88164 through 88167, and 88174 through 88175, providers have to do the actual processing and screening.
 - Interpretation codes are 88141 and 88155, and may be billed in addition to the screening code, if the additional services are provided.
- C. Physical Therapy Services – providers should only bill for those services that the physician or physical therapist employed by the physician performed. In order for the physical therapist to be considered an employee of the provider, the physical therapist must receive a W-2 from the provider (and not a 1099).

The following are not considered pass-through billing:

- A. The service of the performing provider is performed at the place of service of the ordering provider, by an employee of the ordering provider, and is billed by the ordering provider.
- B. One exception relates to services already reimbursed as a component of a DRG or per diem payment, so long as such services are not also billed by the servicing provider.

[Helpful Tips for Filing Claims](#)

Other Insurance Coverage

When filing claims with other insurance coverage, please ensure the following fields are completed and that a legible copy of the EOB from the other insurance coverage is attached to the claim:

CMS-1500 Fields:

Field 9: Other insured's name

Field 9a: Other insured's policy or group number

Field 9b: Other insured's date of birth

Field 9c: Employer's name or school name (not required in EDI)

Field 9d: Insurance plan name or program name (not required in EDI)

UB-04 CMS-1450 Fields:

Field 50a-c: Payer Name

Field 54a-c: Prior payments (if applicable)

Anesthesia Claims

When filing claims for anesthesia services (anesthesia codes 00100-01999), minutes—rather than units—must be billed.

- **Anesthesia Time Units** are reported in one minute increments and noted in the unit's field.
- When **multiple surgical procedures** are done, only report the anesthesia code with the highest base value with the TOTAL time for all procedures. Multiple anesthesia codes will not be reimbursed. Effective on November 14, 2009 with ClaimsXten[®] implementation, if multiple anesthesia codes are billed on the same date of service the line with the lowest charge will be denied.
- **Obstetrical epidural anesthesia** edits may occur when the reported anesthesia time exceeds 2.5 hours if the provider does not have a global contract. A maximum of 2.5 hours of anesthesia time is routinely allowed. Upon review, additional time units may be allowed with documentation that face-to-face time with the obstetrical patient exceeded 2.5 hours.
- When **billing surgery codes**, only bill one unit of service as time is not considered. Surgical codes are reimbursed based on the RVU for the surgical procedure times the surgical conversion factor.
- Procedure codes published in CPT Appendix G include **moderate sedation** (99143 and 99144) as global to performing the procedure and are not eligible for separate reimbursement. [See Reimbursement Policy: *Moderate Sedation*].
- **Moderate sedation** rendered by a provider who is not performing the diagnostic or therapeutic procedure is not eligible for reimbursement in a non-facility setting such as a provider's office or a clinic.
- **Modifier AA** should be reported in the last modifier position when other payment modifiers such as P3 are billed in order to assure additional allowance is added for the payment modifiers. (Modifier AA is not necessary as it is assumed unless there is a "Q" modifier to indicate otherwise.)
- If **more than one payment modifier** is billed, then modifier 99 should be reported in the first position to ensure all payment modifiers are applied. (Example: 99, QX, P3)
- For more information on Anesthesia services, please see Reimbursement Policy: *Anesthesia*.

Correct Coding for Preventive Colonoscopy

Anthem allows for preventive colonoscopy in accordance with state mandates. Colonoscopies which are undertaken as a SCREENING colonoscopy, during which a polyp/tumor or other procedure due to an abnormality are discovered, should be covered under benefits for Preventive Services. This has been an area of much confusion in billing by providers of services. Frequently the provider will bill for the CPT code with an ICD-9 diagnosis code corresponding to the pathology found rather than the "Special screening for malignant neoplasms, of the colon", diagnosis code V76.51.

CMS has issued guidance on correct coding for this situation and states that the *ICD-9 diagnosis code V76.51 should be entered as the primary diagnosis* and that the ICD-9 diagnosis code for any discovered pathology should be entered as the secondary diagnosis on all subsequent claim lines.

Anthem endorses this solution for this coding issue as the appropriate method of coding to ensure that the provider receives the correct reimbursement for services rendered and that our members receive the correct benefit coverage for this important service.

(NOTE: When we start accepting ICD-10 diagnosis codes the appropriate screening diagnosis code will be: Z12.11 - Encounter for screening for malignant neoplasm of colon.)

Medical Records and Situations When Clinical Information Is Required

See the Medical Records and Situations When Clinical Information is Required Submission Guidelines on the last two pages of this section. **Please note requirement for records for prolonged services.**

Modifiers

For more information on modifiers, please see the Claims Editing Software Programs portion of this section and Reimbursement Policy: *Modifier Rules* on the secure provider portal, ProviderAccess.

Late Charges

Late charges for claims previously filed can be submitted electronically. You must reference the original claim number in the re-billed electronic claim. If attachments are required, please submit them on paper with the completed Claim Action Request Form.

Credits

For an original billing the total billed amount for each line must equal the total charges for the claim; therefore, don't itemize credit dollar amounts. If the original services were over-billed, please submit the correction on the Claim Action Request Form.

Negative Charges

When filing claims for procedures with negative charges; please don't include these lines on the claim. Negative charges often result in an out-of-balance claim that must be returned to the provider for additional clarification.

Ambulatory Surgical Centers

When billing revenue codes, always include the CPT or HCPCS code for the surgery being performed. This code is required to determine the procedure, and including it on the claim helps us process the claim correctly and more quickly. Ambulatory surgical claims must be billed on a UB-04 CMS-1450 claims form, unless indicated otherwise in your Agreement.

Date of Current Illness, Injury or Pregnancy

For any 800-900 diagnosis codes, an injury date is required. For a pregnancy diagnosis, the date of the member's last menstrual cycle is required to determine a pre-existing condition.

Type of Billing Codes

When billing facility claims, please make sure the type of bill coincides with the revenue code(s) billed on the claim. For example, if billing an outpatient revenue code, the type of bill must be for outpatient services.

Occurrence Dates

When billing facility claims, please make sure the surgery date is within the service from and to dates on the claim. Claims that include a surgical procedure date that falls outside the service from and to dates will be returned to the provider.

National Drug Codes (NDC)

All Providers and Facilities should supply the 11-digit NDC when billing for injections and other drug items on the CMS1500 and UB04 claim forms as well as on the 837 electronic transactions.

When Healthcare Common Procedure Coding System (HCPCS) codes or Current Procedural Terminology (CPT) codes are billed for drugs administered in a physician office or outpatient facility setting, should include the following:

Unit of Measurement

The unit of measurement codes are also requested to be submitted. The codes to be used for all claim forms are:

- F2 – International unit
- GR – Gram
- ML – Milliliter
- UN – Unit
- ME - Milligram

Location of the NDC

The NDC is found on the label of a prescription drug item and must be included on the CMS-1500 or UB04 claim form or in 837 electronic transactions. The NDC is a universal number that identifies a drug or related drug item.



NDC Number Section	Description
1 (five digits)	Vendor/distributor identification
2 (four digits)	Generic entity, strength and dosage information
3 (two digits)	Package code indicating the package size

Correcting Omission of a Leading Zero

You may encounter NDCs with fewer than 11-digits. In order to submit a claim, you will need to convert the NDC to an 11-digit number. Sometimes the NDC is printed on a drug item and a leading zero has been omitted in one of the segments. Instead of the digits and hyphens being in a 5-4-2 format, the NDC might be printed in a 4-4-1 format (example, 1234-1234-1), a 5-3-2 format (example, 12345-123-12), or a 5-4-1 format (example, 12345-1234-1).

- **If this occurs, when entering the NDC on the claim form, it will be required to add a leading zero to the beginning of the segment(s) that is missing the zero.**
- **Do not enter any of the hyphens on claim forms.**

See the examples that follow:

If the NDC appears as...	Then the NDC...	And it is reported as ...
NDC 12345-1234-12 (5-4-2 format)	Is complete	12345123412
NDC 1234-1234-1 (4-4-1 format)	Needs a leading zero placed at the beginning of the first segment and the last segment	0 12341234 0 1
NDC 12345-123-12 (5-3-2 format)	Needs a leading zero placed at the beginning of the second segment	12345 0 12312
NDC 12345-1234-1 (5-4-1 format)	Needs a leading zero placed at the beginning of the third segment	123451234 0 1

Process for Multiple NDC numbers for Single HCPC Codes

- If there is more than one NDC within the HCPCs code, you must submit each applicable NDC as a separate claim line. Each drug code submitted must have a corresponding NDC on each claim line.
- If the drug administered is comprised of more than one ingredient (i.e. compound or same drug with different strength, etc.), you must represent each NDC on a claim line using the same drug code.

- Standard HCPCS billing accepts the use of modifiers to determine when more than one NDC is billed for a service code. They are:
 - KO – Single drug unit dose formulation
 - KP – First drug of a multiple drug unit dose formulation
 - KQ – Second or subsequent drug of a multiple drug unit dose formulation
 - JW – Drug amount discarded /not administered to the patient

How/Where to Place the NDC on a Claim Form

CMS 1500 Claim Form:

- Reporting the NDC requires using the upper **and** lower rows on a claim line. Be certain to line up information accurately so all characters fall within the proper box and row.
- **DO NOT bill more than one NDC per claim line.**
- Even though an NDC is entered, a valid HCPCS or CPT code must also be entered in the claim form.
- If the NDC you bill does not have a specific HCPCS or CPT code assigned, please assign the appropriate miscellaneous code per Correct Coding Guidelines.
- The unit of service for the HCPCS or CPT code is very important. Units for injections must be billed consistent with the HCPCS or CPT description of the code.

The following table provides elements of a proper NDC entry on a CMS-1500 claim form.

All Elements are requested:

How	Example	Where
Enter a valid NDC code including the N4 qualifier	NDC 00054352763 is entered as N400054352763	Beginning at left edge, enter NDC in the shaded area of box 24A
Enter one of five (5) units of measure qualifiers; <ul style="list-style-type: none"> • F2 – International Unit • GR - Gram • ML - Milliliter • UN - Units • ME - Milligrams and quantity, including a decimal point for correct reporting	GR0.045 ML1.0 UN1.000	In the shaded area immediately following the 11-digit NDC, enter 3 spaces, followed by one of five (5) units of measure qualifiers, followed immediately by the quantity
Enter a valid HCPCS or CPT code	J0610 "Injection Calcium Gluconate, per 10 ml" is billed as 1 unit for each 10 ml ampul used	Non-shaded area of box 24D

24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER												
1																				
2																				
3																				
4																				
5																				

Enter NDC in shaded area of box 24A

UB04 Claim Form:

- Even though an NDC is entered, a valid HCPCS or CPT code must also be entered in the claim form.
- If the NDC you bill does not have a specific HCPCS or CPT code assigned, please assign the appropriate miscellaneous code per Correct Coding Guidelines.
- DO NOT bill more than one NDC per claim line.
- The unit of service for the HCPCS or CPT code is very important. Units for injections must be billed consistent with the HCPCS or CPT description of the code.

The following table provides elements of a proper NDC entry on a UB04 claim form.

All Elements are requested:

How	Example	Where
Enter a valid revenue code	Pharmacy Revenue Code 0252	Form locator (box) 42
Enter 11- digit NDC, including the N4 qualifier	NDC 00054352763 is entered as N400054352763	Beginning at left edge, enter NDC In locator (box) 43 currently labeled as "Description"
Enter one of five (5) units of measure qualifiers; <ul style="list-style-type: none"> • F2 – International Unit • GR - Gram • ML - Milliliter • UN – Units • ME - Milligrams and quantity, including a decimal point for correct reporting	GR0.045 ML1.0 UN1.000	Immediately following the 11 digit NDC, enter 3 spaces followed by one of five (5) units of measure qualifiers, followed immediately by the quantity.
Enter a valid HCPCS or CPT Code	J0610 "injection Calcium, per 10ML" is billed as 1 unit for each 10ML ampul used	Form locator (box 44)

Sample Images of the UB04 Claim Form

42 REV. CO.	43 DESCRIPTION	44 HCPCS / RATE / ICD9 CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NONCOVERED CHARGES	49
1						0:00	1
2						0:00	2
3						0:00	3
4							4
5							5

Enter NDC
in locator
(box) 43

42 REV. CO.	43 DESCRIPTION	44 HCPCS / RATE / ICD9 CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NONCOVERED CHARGES	49
1	N4##### GR0.045	J####	MMDDYY	1	##.##	0:00	1

837 P And 837 I Reporting Fields

Billing or Software Vendor:

You will need to notify your billing or software vendor that the NDC is to be reported in the following fields in the 837 format:

Tips for Using NDCs When Submitting Electronic Claims

Loop	Segment	Element Name	Information	Sample
2410	LIN02	Product or Service ID	Enter product or NDC qualifier N4	LIN**N4*01234567891~
2410	LIN03	Product or Service ID	Enter the NDC	LIN**N4*01234567891~
2410	CTP04	Quantity	Enter quantity billed	CTP****2*UN~
2410	CTP05-1	Unit of Basis for Measurement Code	Enter the NDC unit of measurement code: F2: International unit GR: Gram ML: Milliliter UN: Unit ME: Milligram	CTP****2*UN~
2410	REF01	Reference ID Qualifier (used to report Prescription # or Link Sequence Number when reporting components for a	VY: Link Sequence Number XZ: Prescription Number	REF01*XZ*123456~

Loop	Segment	Element Name	Information	Sample
		Compound Drug)		
2410	REF02	Reference Identification	Prescription Number or Link Sequence Number	REF01*XZ*123456~

[Claims Submissions for Pharmaceuticals](#)

Provider and Facility agree to submit the national drug code (NDC) on claims submitted for FDA approved prescription medications.

[National Provider Identifier](#)

The National Provider Identifier (“NPI”) is one provision of the Administrative Simplification section of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Anthem requires the NPI (as your only provider identifier) on electronic and paper transactions.

Location of the NPI on claim forms

NPI location for electronic transactions:

- The NPI will be reported in the provider loops on electronic transactions. The following elements are required:
 - The NM108 qualifier will be “XX” for NPI submission.
 - The NM109 field will display the 10-digit NPI.
 - The TIN will be required in the Ref segment when the NPI is reported in the NM109.
 - The REF01 qualifiers (EI = TIN; SY = Social Security number)
 - The REF02 field will display the provider’s or facility’s TIN or Social Security number.
- The chart below outlines the changes for 837 professional, institutional and dental claims:

Field	Locator	Changes
Primary Identifier Qualifier	NM108 qualifier	Key “XX” for NPI submission.
	NM109 field	Key the 10-digit NPI. (The tax ID number will be required in the Ref segment when the NPI is reported in the NM109 locator.) This requirement of Tax ID will be on Billing, Pay to, and rendering provider loops only.
Secondary Identifier Qualifier	REF01 qualifiers	Key “EI” (tax ID) or “SY” (Social Security number).
Secondary Identifier	REF02	Key the provider tax ID number or Social Security number.

Field	Locator	Changes
Other Identifier not considered legacy IDs Optional	REF01	Key “LU” (location number), “OB” (state license number)
Other Identifier not considered legacy IDs Optional	REF02	Key the location number or state license number

NPI location on the electronic remittance advice (835):

Loop/Segment	Institutional	Professional
Loop 1000B; N103	XX	XX
Loop 1000B; N104	NPI	NPI
Loop 1000B; REF01	TJ	TJ
Loop 1000B; REF02	TIN	TIN
Loop 2000; TS301	Not used	Not used
Loop 2100; NM108	XX	XX
Loop 2100; NM109	NPI	NPI

NPI location on paper forms:

- Revised CMS-1500 (08/05)
 - The NPI will be displayed in box/field 17b for the **referring** provider.
 - The NPI will be displayed in box/field 24j for the **rendering** provider.
 - Locators 32a and 33a are also designated for the NPI for the **servicing** provider locations and pay to/billing provider location.

14. DATE OF CURRENT: MM DD YY			ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										
17b. NPI										
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	
32. SERVICE FACILITY LOCATION INFORMATION						33. BILLING PROVIDER INFO & PH # ()				
a. NPI b.						a. NPI b.				

NPI location on paper forms:

- UB-04 CMS-1450
 - The NPI will be displayed in the following boxes/fields:
 - Box/field 56 for the **facility**
 - Box/field 76 for the **attending physician**
 - Box/field 77 for the **operating physician**
 - Box/fields 78 and 79 for **other provider** type (optional)

The diagram illustrates the placement of NPI fields on the UB-04 CMS-1450 form. It shows the following fields and their locations:

- Box 56 NPI:** Located in the top right section of the form, labeled '56 NPI'.
- Box 57 OTHER PRVID:** Located below Box 56, labeled '57 OTHER PRVID'.
- Box 76 ATTENDING NPI:** Located in the middle left section, labeled '76 ATTENDING NPI'.
- Box 77 OPERATING NPI:** Located below Box 76, labeled '77 OPERATING NPI'.
- Box 78 OTHER NPI:** Located below Box 77, labeled '78 OTHER NPI'.
- Box 79 OTHER NPI:** Located below Box 78, labeled '79 OTHER NPI'.

Arrows indicate the flow of information from these fields to the provider information section at the bottom of the form, specifically to the fields labeled 'NPI' and 'NPI TYPE'.

Timely Filing

Timely Filing for Claims

Claims must be submitted within the timely filing timeframe specified in your contract.

All additional information reasonably required by Anthem to verify and confirm the services and charges must be provided on request. The provider must complete and return requests for additional information within thirty ("30") calendar days of Anthem's request.

Claims submitted after the timely filing period expires will be denied, unless proof of timely filing can be demonstrated according to the guideline listed below.

Proof of Timely Filing

Waiver of the timely filing requirement is only permitted when Anthem has received documentation indicating the member or provider originally submitted the claim within the applicable timely filing period.

The documentation submitted **must** indicate the claim was originally submitted before the timely filing period expired.

Acceptable documentation includes the following:

1. A copy of the claim with a **computer-printed filing date** (a handwritten date isn't acceptable)
2. An original fax confirmation specifying the claim in question and including the following information: date of service, amount billed, member name, original date filed with Anthem and description of the service
3. The provider's billing system printout showing the following information: date of service, amount billed, member name, original date filed with Anthem and description of the service

If the provider doesn't have an electronic billing system, approved documentation is a copy of the member's chart indicating the billed date and/or a copy of the billing records indicating the billed date, and the information listed above.

4. If the claim was originally filed electronically, a copy of Anthem's electronic Level 2 or your respective clearinghouse's acceptance/rejection claims report is required; a copy can be obtained from the provider's EDI vendor, EDI representative or clearinghouse representative. The provider also must demonstrate that the claim and the member's name are on the original acceptance/rejection report. Note: When referencing the acceptance/reject report, the claim must show as accepted to qualify for proof of timely filing. Any rejected claims must be corrected and resubmitted within the timely filing period.
5. A copy of the Anthem letter requesting additional claim information showing the date information was requested.

If the provider originally received incorrect insurance information, the provider has thirty (30) calendar days from the date the provider is advised of the correct insurance information to file the claim with the correct carrier.

Appeals for claims denied for failing to meet timely filing requirements must be submitted to Anthem **in writing**. Anthem doesn't accept appeals over the phone.

Any exceptions to the proof of timely filing policy require the signature of the person in the director-level position or above in the applicable Anthem department.

Please send all claims data to the applicable address listed in the **Alpha Prefix Reference List** section.

Electronic Data Interchange (“EDI”) Overview

Anthem recommends using the EDI system for Claims submission. Electronic Claims submissions can help reduce administrative and operating costs, expedite the Claim process, and reduce errors. Providers and Facilities who use EDI can electronically submit Claims and receive acknowledgements 24 hours a day, 7 days a week.

Electronic Funds Transfer Election – Should Provider or Facility elect to receive payments via Electronic Fund Transfer, such election may be deemed effective by Anthem for any Claim your Agreement with Anthem pertains to. Anthem may share information about Providers or Facilities, including banking information, with third parties to facilitate the transfer of funds to Provider or Facility accounts.

There are several methods of transacting Anthem Claims through the Electronic Data Interchange process. You can use electronic Claims processing software to submit Claims directly, or you can use an EDI vendor that may also offer additional services, including the hardware and software needed to automate other tasks in your office. No matter what method you choose, Anthem does not charge a fee to submit electronically. Providers and Facilities engaging in electronic transactions should familiarize themselves with the HIPAA transaction requirements.

Additional Information

For additional information concerning electronic Claims submission and other electronic transactions, you can go to the Electronic Data Interchange (EDI) website at www.anthem.com/edi, select Colorado from drop down list and [enter](#), or on the Provider Home page of anthem.com select the link titled “[Electronic Data Interchange \(EDI\)](#)”.

Explanation of Benefits (“EOB”) and Remittance Advice (“RA”)

The EOB or RA will include the information needed to post claims for each member included during this processing cycle. Anthem will send one check to cover the total amount on the EOB/RA. To receive your EOBs/RAs electronically, please call 800-332-7575, or download the 835 registration form at anthem.com/edi, select state.

EOBs and RAs are in the same format for all local and BlueCard members. See the sample EOB and RA below.

EXPLANATION OF BENEFITS

ISSUE DATE	PAGE	C000002
May 26, 2006	00002 OF 00003	

ABC MEDICAL GROUP
PO BOX 8500
DENVER, CO 80273

Sequence Number: 232763722 200600005
Provider ID: 232763722
NETWORK PROVIDER: N
FOUNDATION PHYSICIAN: N

Alpha Prefix

Patient Name: DOE, JOHN Claim ID: 06129111059**			ID Number: AAA031A06010 Acct Nbr:			Group Nbr: CU0200		
SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
01/12/06	90921	001	650.00	354.82	295.18/01		141.93/02	212.89
TOTAL THIS CLAIM			650.00	354.82	295.18	0.00	141.93	212.89
FOR INFORMATION CALL: 888-817-8737								

MESSAGES:

- 01 - This is the amount in excess of the allowed expense for a non-participating provider.
02 - This balance is the member's coinsurance responsibility.

PAYMENT SUMMARY

CLAIMS PAYMENT/ADJUSTMENTS	PROCESSED	PAID AMOUNT
Total Claims	212.89	212.89
Adjustments Payable Provider	0.00	0.00
Deferred Adjustments Due	0.00	0.00
Sub Total		212.89

CHECK AMOUNT (CHK # 7000004038)

\$212.89

THIS IS NOT A BILL

SEE LAST PAGE FOR IMPORTANT INFORMATION

Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc.
* Registered Marks Blue Cross and Blue Shield Association.

1000B000005

NM223A 07/05

EOB Data Dictionary

The following list provides definitions for all data fields in the EOB, which we send to providers who submit claims on a CMS-1500 Form.

Account Number	The account number your office has assigned to our member's account. This number will be repeated on each claim/EOB.
Adjustment Information	This line follows the claim detail and indicates if the claim is an adjustment. If it's an adjustment, the original claim's EOB sequence number is cross-referenced.
Adjustments Payable (to the) Provider	A supplemental adjustment that will increase the Anthem paid amount for a claim and will be added to the current EOB
Allowed Amount	The schedule of maximum allowable amounts
Billed Amount	The amount the provider billed Anthem for the service
Claim ID	The document control number (DCN), which is the number Anthem assigns for each claim, document and letter which is received by Anthem. The first five numbers are the Julian date.
Claims Payment	The allowed amount minus the deductible amount minus the coinsurance/copayment amount, i.e., the allowed amount minus the member's financial responsibility
Claims Payment/Adjustments	A summary of all the claims and adjustments from the previous pages of the EOB found in the Payment Summary box on the last page of the EOB
Claim Received Date	The date Anthem received the original claim – (which is the same as the DCN date)
Coinsurance/Copayment Amount	The amounts, which are determined by the member's Health Benefit Plan, that the member must pay
Deductible Amount	The amount, which is determined by the member's Health Benefit Plan, that the member must pay before benefit payments begin
Deferred Adjustments Due	Adjustment(s) indicated on the current EOB. The indicated amount(s) will be withheld from an EOB 30 days from the current EOB date – not from this EOB. (Note: this amount is not taken from this RA, but will be taken from a future remittance as a "Deferred Claims Adjustment Withhold" if the overpayment is not received within the 30 day time period.)
Deferred Claims Adjustment Withhold	A list of any overpayment(s) being deducted from the current payment. Each claim is itemized and includes the member's name, account number, service dates, sequence number, reason code, withhold amount and the telephone number to call for inquiries. (Note: a sequence number will be displayed referring to the original RA where the notification occurred titled "Deferred Adjustment Due").
ID Number	The member's unique Anthem ID number, which has an alpha character in the fourth position (Note: all local members' ID numbers include a 3 character alpha prefix which is part of their member ID number. For local member's only, alpha prefix is not included on the EOB)

REMITTANCE ADVICE

ISSUE DATE	PAGE	C000001
May 26, 2006	00002 OF 00004	

290021
ABC Hospital Medical C
File 50026
Denver, CO 80273

SEQUENCE NUMBER: 290021-004 200600037

O U T P A T I E N T								
PATIENT ACCT NUMBER	PATIENT NAME	CONTRACT TYPE	SERVICE DATES FROM TO	APPROVED DAYS	TOTAL CHARGES	PROVIDER LIABILITY		
CLAIM NUMBER	NETWORK CLAIM NBR	ACTION CODE	REIM RATE / NETWORK	PAID DAYS	COVERED CHARGES	MEMBER LIABILITY	CLAIMS PAID AMOUNT	
734714-0001	DOE, J.	PBEX	052606 052606	000....	608.80	489.64		
06157055547 **	AAA 995A52306 Alpha Prefix	PAID	204%/NW01	1	608.80	0.00	119.16	
734228-0001		PBOP	052506 052506	000....	127.05	0.00		
06157055549	JONES, J. 531A55079	PAID	2515.00/NW01	1	127.05	12.70	114.35	
728802-0001		IPSE	042006 042006	000....	383.40-	21.40-		
06116056622 **	WILSON, W 942A62626	S90	100%/NW01	1	21.40-	362.00-	0.00	

... REFER TO SEQ.NO. 050090-001 200600722

728802-0001	WILSON, W	IPSE	042006 042006	000....	383.40	287.19		
06116056622 **	942A62626	S90	100%/NW01	0	383.40	28.86	# 67.35	
731984-0001	JOHNSON, J	PPO *	050906 050906	000....	1117.99	357.99		
06146055590	85231314	PAID	100%/NW01	0	1117.99	75.00	685.00	

EXPLANATION OF CODES

CONTRACT TYPES:

NETWORK:

ACTION CODES:

COEB: Premier \$25

NW01 ANTHEM

COEE: \$35 Genrx

COSL: BP Opt I 15/40/60/30%

COED: \$40 Copay

COEA: Premier \$15

COEG: H S A 2000

THIS IS NOT A BILL

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NM223B 07/05

[RA Data Dictionary](#)

The following list provides definitions for all data fields in the RA, which we send to providers who submit claims on a UB-04 CMS-1450 Form.

Action Code	A three-digit code indicating the final outcome of the claim. If the claim is paid, "PAID" will display. A list of applicable codes is provided in the RARA explanation of codes section.
Approved Days	Inpatient days approved by utilization review. For outpatient days, approved days will be displayed as "000."
Check Amount	The total amount paid for the claims listed in the RA.
Claim Number	The unique document control number (DCN), which is the number Anthem assigns for each claim received. The first five numbers are the Julian date.
Claims Paid Amount	The total amount to be paid to the provider for each claim listed on the RA.
Claims Payments/Adjustments	A summary of payments and adjustments for all inpatient and outpatient claims detailed in the RA.
Contract Type	The type of Anthem coverage the member has. A list of contract types for claims in the specific RA is displayed in the explanation of codes section.
Covered Charges	The maximum allowed amounts for the services covered by the member's Health Benefit Plan.
Deferred Claims Adjustment Withhold	Any overpayment adjustment withholds that have not been repaid to Anthem within the 30-day timeframe. Each claim is itemized and includes information about the overpayment adjustment withhold. The RA check will be reduced by the amount(s) identified in this section. (Note: a sequence number will be displayed referring to the original RA where the notification occurred titled "Deferred Inpatient/Outpatient Adjustment Due").
Deferred Inpatient Adjustments Due	The amount of overpayment adjustment for an inpatient claim identified on the RA. This amount is deferred for 30 days and notification letters are sent to the provider. (Note: this amount is not taken from this RA, but will be taken from a future remittance as a "Deferred Claims Adjustment Withhold" if the overpayment is not received within the 30 day time period.)
Deferred Outpatient Adjustments Due	The amount of overpayment adjustment for an outpatient claim identified on the RA. This amount is deferred for 45 days and notification letters are sent to the provider. (Note: this amount is not taken from this RA, but will be taken from a future remittance as a "Deferred Claims Adjustment Withhold" if the overpayment is not received within the 30 day time period.)
Explanation of Codes	Definitions for the contract types, networks utilized and action codes listed in the claim detail line information of the RA and displayed on the second-to-last page of the RA.
Payment Summary	The last page of the RA, which displays the summary breakdown of payments, adjustments, overpayment adjustment withholds and interest payments.

Inpatient Adjustments Payable Provider	The total amount of all inpatient claims adjustments identified on the RA that are to be credited to the provider.
Issue Date	The date the RA was generated.
Member ID number	The member's unique Anthem ID number. The unique ID is a series of nine characters with a letter in the fourth position. (Note: all local members' ID numbers include a 3 character alpha prefix which is part of their member ID number. For local member's only, alpha prefix is not included on the EOB)
Member Liability	The amount (which is determined by the member's Health Benefit Plan) the member must pay before benefit payments begin including copayments/coinsurance, deductible, and non-Covered Services.
Network	The grouping of health care providers Anthem contracts with to provide health care services to our members.
Network Claim NBR	Not currently used in the RA.
Outpatient Adjustments Payable Provider	The total amount of all outpatient claim adjustments identified on the RA that are to be credited to the provider.
Paid Amount	The total amounts to be paid for each of the following categories: <ul style="list-style-type: none"> • Total inpatient claims • Inpatient adjustments payable to the provider • Total outpatient claims • Outpatient adjustments payable to the provider This column does not include the deferred inpatient or outpatient adjustments due amounts, because the overpayment adjustment is deferred for 30 days.
Paid Days	The total number of days for which the claim was paid, which is usually equal to or less than the approved days for inpatient claims. For outpatient claims, "1" will usually be indicated, unless the total "occurrences" for the particular procedure is indicated.
Patient Account Number	A patient identifier issued by the provider for its in-house records and captured only if submitted by the provider.
Patient Name	The last name and first initial of the patient for whom the claim was submitted.
Processed	The total amounts identified in the RA for each of the following categories: <ul style="list-style-type: none"> • Total inpatient claims • Inpatient adjustments payable to the provider • Deferred inpatient adjustments due • Total outpatient claims • Outpatient adjustments payable to the provider • Deferred outpatient adjustments due A total isn't indicated for this column because it only identifies the activity of the RA.
Provider Liability	The amount of write-off, based on the provider's contractual agreement with Anthem.
Refer to Seq. No. ____	An identifier in the body of the RA that a claim adjustment occurred and which is a reference number to the previous RA where the original claim was processed.
Reimbursement Rate	The percentage(s), Per Diem amount or a flat-dollar amount at which the claim is reimbursed for the service or procedure.

Remittance Advice	A reimbursement report with detailed line information and a payment summary and issued electronically or on paper from Anthem's claims processing system.
Rsn Cde	A three-digit reason code indicating the outcome of the claim and which is the same as the action code but identified as a reason code for deferred claims adjustment withholds. The reason code definition is displayed below the withhold information.
Sequence Number	A series of numbers assigned to each RA that include the Medicare number or TID number, the current year, and a sequential number following the year (e.g., sequence number 200400004 indicates it's the fourth RA generated for the provider in the year 2004). The sequence number restarts at the beginning of each year.
Service Dates	The to/from dates indicated for an overpayment adjustment withhold in the financial summary.
Service Dates From/To	The dates of service for the claim.
Service Type	Indicates whether the claim is for inpatient or outpatient services in the deferred claims adjustment withhold section of the financial summary.
Statutory Interest on Delayed Payment	An interest payment from the processing date for a claim not paid within the required timeframe.
Subtotal	The total amount Anthem is paying for the claims listed in the RA.
Total Charges	The amount the provider bills for the service or procedure.
Total Inpatient Claims	The initial inpatient claims total listed in the RA and which does not include any adjustment amounts identified in the RA.
Total Outpatient Claims	The initial outpatient claims total listed in the RA and which does not include any adjustment amounts identified in the RA.
Withhold Amount	The amount of the overpayment adjustment withhold that will be deducted from the RA check total.

[Provider EOB/RA Frequently Asked Questions](#)

Reference our online Provider Toolkit for information on frequently asked questions about our EOBs and RAs. Find out answers to common questions about:

- Miscellaneous “take backs”
- Notice of a “take back” vs. an actual “take back”
- Zero-pay voucher

Access our Provider Toolkit information online. Go to **anthem.com**, select the **Provider** link in top center of the page. Select **Colorado** from drop down list and **enter**. From the **Provider Home** tab, select the link titled **Provider Communications and Education**, then **Provider Toolkit**, and “[Provider EOB/RA Frequently Asked Questions](#)”.

[Situations When Clinical Information Is Required](#)

The following claims categories may routinely require submission of clinical information before or after payment of a claim:

- Claims involving pre-certification/prior authorization/pre-determination or some other form of utilization review, including, but not limited to the following:
 - Claims pending for lack of pre-certification or prior authorization
 - Claims involving Medical Necessity or experimental/investigational determinations
 - Claims for pharmaceuticals that require prior authorization
- Claims involving certain modifiers, including, but not limited to, modifier 22
- Claims involving unlisted codes
- Claims for which Anthem can't determine, from the face of the claim, whether it involves a covered service and therefore can't make the benefit determination without reviewing medical records (examples include, but aren't limited to, pre-existing condition issues [for grandfathered policies of the Affordable Care Act], emergency service-prudent layperson reviews and specific benefit exclusions)
- Claims Anthem has reason to believe involve inappropriate (including fraudulent) billing
- Claims, including high-dollar claims, that are the subject of an internal or external audit
- Claims for members involved in case management or disease management
- Claims that have been appealed or are otherwise the subject of a dispute, including claims being mediated, arbitrated or litigated
- Other situations in which clinical information may routinely be requested:
 - Requests related to underwriting, including, but not limited to, member or physician misrepresentation/fraud reviews and stop-loss coverage issues
 - Accreditation activities
 - Quality improvement/assurance activities
 - Credentialing
 - Coordination of benefits
 - Recovery/subrogation

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

Medical Records Submission Guidelines

Submission of Medical Records for Claims (applies to both EDI and paper claims)

Medical records are required for items 1 through 8 below and must be submitted with the claim to help ensure prompt processing of the claim.

1. All miscellaneous HCPCS and CPT codes
2. All miscellaneous J**** codes
3. All IV therapy drugs and home infusion
4. Remicade, Synagis, Synvisc
5. Change of diagnosis (diagnosis code)
6. Unlisted procedures
7. All DME HCPCS codes
8. Surgery codes with Modifier 22

Please note: This list doesn't apply to inpatient facility services.

- If medical records aren't required per the above list, please don't submit records with the claim.
- If medical records are required, please refer to the next section to determine the type of record you must submit.
 - **EDI submitted claims would include the "PWK" Paperwork Included segment to let our processors know there is an attachment/documentation included for this claim.**
- Medical records previously submitted as part of pre-certification (pre-service review) may meet the requirements for medical records. Please review "Types of Medical Records Required" below.

Types of Medical Records Required (for items 1 through 7 above)

CPT Codes	Medical Record Type
99000 – 99999	Detailed description of services
01999	Anesthesia record
10000 – 69999	Operative report or detailed description of services
70000 – 79999	X-ray report or detailed description of services (operative report)
80000 – 89999	Lab report or documentation of Medical Necessity
90000 – 98000	Office notes or detailed description of services
Pharmaceuticals	Medical Record Type
J3490, J8999, J9999	Name of drug, physician's orders, NDC code
Synvisc	Name of drug, physician's orders, NDC code
IV therapy (including home infusion)	Name of drug, physician's orders, NDC code, treatment plan (if applicable)
Remicade, Synagis	Name of drug, physician's orders, NDC code, patient's weight at time of drug administration
Miscellaneous HCPCS	Medical Record Type
E1399, L0099 - L9900	Description, order invoice (if applicable)
Other misc. HCPCS codes	Lab report, test results or documentation of Medical Necessity, as appropriate
Other	Medical Record Type
DME HCPCS codes	Documentation of Medical Necessity and physician's orders

Additional Medical Records Anthem Also May Request

Some situations may require additional medical records. Although these situations may not have specific rules and guidelines, Anthem will make every attempt to make these requests explicit and limited to the minimal requests necessary to render a decision. Examples include, but aren't limited to, the following:

- Medical records requested by a member's Blue Cross and/or Blue Shield home plan (National Accounts)
- Federal Employee Plan requirements
- Review and investigation of claims (e.g., pre-existing conditions [for grandfathered policies of the Affordable Care Act], lifetime benefit exclusions)
- Medical review and evaluation
- Requests for retro authorizations
- Medical management review and evaluation
- Underwriting review and evaluation
- Adjustments
- Appeals
- Quality management (quality of care concerns)
- Records documenting prolonged services

[Claim Action Request Procedures](#)

When to Submit a Claim Action Request

Please submit claim action requests only when the claim has been processed through finalization, and the claim appears as paid or denied on your EOB/RA or when you have received a letter requesting additional information before the claim can be processed. A claim action request may be needed as the result of a processing error, correcting claim information, missing or incomplete information, etc.

Anthem provides the claim action request process as an informal way for providers to request reconsideration of a claim determination made by Anthem. The claim action request process isn't the same as an appeal. However, it's often the quickest way to process a claim reconsideration.

Please note: Please direct claim status inquiries to our interactive voice response ("IVR") system, to our website at anthem.com (see the Provider Portal Connectivity Options section for more details) or to provider customer service (see the Telephone/Address Directory section for the phone numbers). Sending claim status inquiries via a Claim Action Request Form will delay the response to your inquiry.

How to Submit a Claim Action Request

- Requests must be submitted on a Claim Action Request Form, completed entirely.
- Submit only one claim on each Claim Action Request Form.
- Include the corresponding claim control number for each action request.
- Specify in detail the issue and the action requested.
- Attach all documentation to support the action request, i.e., medical records, letter of appeal, corrected claim form, etc.

How to Obtain a Claim Action Request

This form is available in electronic format for typing your information. Go to **anthem.com**, select the **Provider** link in top center of the page. Select **Colorado** from

drop down list and **enter**. From the **Answers@Anthem** tab, select the link titled “**Download Commonly Requested Forms**”, then “[Claim Action Request Form](#)”.

Where to Send Completed Claim Action Request

For Local Plan members and BlueCard members (all alpha prefixes other than R + 8 numerics):

Anthem Blue Cross and Blue Shield
P.O. Box 5747
Denver, CO 80217-5747

For Federal Employee Program (FEP) members (alpha prefix R + 8 numerics):

Federal Employee Program
P.O. Box 105557
Atlanta, GA 30348-5557

Who to Contact with Questions about Claim Action Requests

Please call provider customer service (see the [Alpha Prefix Reference List](#) for the appropriate phone number).

Billing and Reimbursement Guidelines

[Professional Reimbursement Policies](#)

While some of our Reimbursement Policies are mentioned below, the complete collection of our Reimbursement Policies are located on our secure provider portal, ProviderAccess.

Go to **anthem.com** and click the **Providers** link in the top center of the page. Select **Colorado** from the state drop-down box, and **Enter**. From the **ProviderAccess Login** tout (blue box on the left side of the page), select **Medical** from the drop down list and click on the [login](#) button. Enter your user **name** and **password**. Once logged into ProviderAccess, from the **Overview** tab, under the **Policies and Procedures** section, select the link titled “**View Reimbursement Policies**”. From the Anthem’s West Clinical Policies – Overview page, select **Continue**. Select **All Clinical Policies** tab. Select the **Reimbursement Policies** link, then select the policy you would like to view.

If you are not currently a registered user of our secure provider portal, see the ProviderAccess section of this Manual.

Claims Editing Software Programs

Services must be reported in accordance with the reporting guidelines and instructions contained in the American Medical Association (“AMA”) CPT Manual, CPT® Assistant, and HCPCS publications. Providers are responsible for accurately reporting the medical, surgical, diagnostic, and therapeutic services rendered to a member with the correct CPT and/or HCPCS codes, and ICD-9 codes and for appending the applicable modifiers, when appropriate.

Effective with claims processed on or after November 14, 2009, Anthem is utilizing a claims editing software product from McKesson, Inc., called ClaimsXten. ClaimsXten includes the McKesson incidental, mutually exclusive and unbundled/rebundle edits as well as other editing rules including National Correct Coding Initiative (“NCCI”) edits, CMS Medically Unlikely Edits (“MUEs”) and other frequency edits. It also provides the editing tools to incorporate the administration of many of our reimbursement policies.

Anthem upgraded our claims editing software, ClaimsXten version 4.1, to ClaimsXten version 4.4 on February 16, 2013 in order to meet the requirements of ICD-10 reporting and add included additional edits to support new reimbursement policies.

The ClaimsXten editing software is used to evaluate the accuracy of medical claims and their adherence to accepted CPT/HCPCS/ICD-9 coding practices and it allows us to monitor the increasingly complex developments in medical technology and correct procedure coding used to process physician payments. American Medical Association, CPT, CPT Assistant, coding guidelines developed from national specialty societies, CMS, NCCI, HCPCS, American Society of Anesthesiology (“ASA”), and other standard-setting organizations for claims billing procedures are considered in developing Anthem’s coding and reimbursement edits and policies.

ClaimsXten will continue to be updated on a quarterly basis. In addition to adding new CPT codes, HCPCS codes, and NCCI edits, McKesson continues to add and revise content based on ongoing review of the entire knowledge base. This continuous process helps to ensure that the clinical content used in ClaimsXten is clinically appropriate and withstands the scrutiny of both payers and providers. The quarterly updates are incorporated without specific notification.

Anthem has made customizations to the ClaimsXten software to support our reimbursement policies. (The list of reimbursement policies with Customized Edits and the Reimbursement Policies are posted on our provider portal, ProviderAccess. If you are not currently registered, see the Provider Portal Connectivity section for further details).

Please see Reimbursement Policies: *Claims Editing Overview* for more information on individual edits and the full content of the policies mentioned below.

Some of the edits ClaimsXten performs are listed below:

- **Procedure unbundling** occurs when two (2) or more procedures are used to describe a service when a single, more comprehensive procedure exists that

more accurately describes the complete service performed by a provider. In this instance, the two (2) codes may be replaced with the more appropriate code by our bundling system.

- An **incidental procedure** is performed at the same time as a more complex primary procedure. The incidental procedure doesn't require significant additional physician resources and/or is clinically integral to the performance of the primary procedure.
- **Mutually exclusive procedures** are two (2) or more procedures usually not performed during the same patient encounter on the same date of service. Mutually exclusive rules may also govern different procedure code descriptions for the same type of procedure for which the physician should be submitting only one (1) procedure.
- **National Correct Coding Initiative ("NCCI" or "CCI") edits** developed by CMS will be applied effective on or after November 14, 2009 with the implementation of ClaimsXten. These edits will be applied to code pairs after the standard ClaimsXten incidental, mutually exclusive and/or re-bundled edits have been applied and will follow the NCCI modifier allowed designations.
 - Effective with the upgrade to ClaimsXten v4.4, Anthem has adopted the CMS code pair superscript modifier override guidelines for Non Site Specific Modifiers: 25, 58, 59, 78, 79 and 91. To override an edit, when applicable (superscript = 1) by NCCI guidelines, the over-riding modifier must be appended to the denied or "column 2" code).
- **Duplicate procedure** editing involves duplicate procedures submitted with the same date of service. Duplicate procedures include the following:
 - When the description of the procedure contains the word "bilateral," the procedure may be performed only once on a single date of service.
 - When the description of a procedure code contains the phrase "unilateral/bilateral," the procedure may be performed only once on a single date of service.
 - When the description of the procedure specifies "unilateral" and there is another procedure whose description specifies "bilateral" performance of the same procedure, the unilateral procedure may not be submitted more than once on a single date of service.
 - When the description of one procedure specifies a "single" procedure and the description of a second procedure specifies "multiple" procedures, the single procedure may not be submitted more than once on a single date of service.
- The **global duplicate value** is the total number of times it's clinically possible or Medically Necessary to perform a given procedure on a single date of service across all anatomic sites.

- **Age edits** occur when the provider assigns an age-specific procedure or diagnosis code to a patient whose age is outside the designated age range.
- **Gender edits** occur when the provider assigns a gender-specific procedure or diagnosis code to a patient of the opposite sex.
- **Frequency edits** occur when a procedure is billed more often than would be expected. Frequency edits occur when:
 - Base procedure codes are billed with a quantity greater than one on a single date of service.
 - Procedures whose description includes a numeric definition or the term “single,” “one or more”, bilateral or “multiple” are billed with a quantity greater than one (1) on a single date of service.
 - In the case of procedures that are allowed with more than one (1) unit per date of service, the line item that exceeds the maximum allowed per date of service will be denied and replaced with a new corrected line item showing the appropriate number of units.
 - For more information on frequency edits refer to Reimbursement Policy: *Frequency Editing*
- **Pap Smear lab codes with E/M codes** are not eligible for separate reimbursement. In most cases when a family physician, internist, obstetrician/gynecologist or other qualified provider submits a cytopathology/Pap smear code they are not the physicians conducting the screening and/or interpreting the Pap smear. They are the providers who obtained the specimen. The pathologist preparing and interpreting the cytopathology/Pap smear must bill for this service separately.
 - Therefore, Anthem Bundles 88141-88155, 88164-88167, 88174-88175 Pap smear (Papanicolaou test or cytopathology smear) as mutually exclusive with E/M codes.
- **History Editing Occurs when a** previously submitted historical claim that is related to current claim submission is identified. This identification/edit may result in adjustments to claims previously processed. An example of such a historical auditing action would occur when an E/M visit is submitted on one (1) claim and then a surgery for the same service date is submitted on a different claim. If a determination that the E/M visit paid in history is included in the allowable for the surgery, an adjustment of the E/M claim will be necessary, this may result in an overpayment recovery.
 - History editing capability enables us to auto-adjudicate some of our reimbursement policies including, but not limited to; DME, global surgery, multiple visits per day, pre/post-operative visits, new patient visits, frequency rules, incidental, mutually exclusive and rebundle edits and maternity services.

- This edit was effective with claims processed on and after the ClaimsXten implementation on November 14, 2009.
- **Bundled Services and Supplies edits** occur when the editing system identifies certain services and supplies that are considered to be an integral component of the overall medical management service and care of the member and are not reimbursed separately.
 - These services and/or supplies may be reported with another service or as a stand-alone service.
 - When reported with another service, modifier 59 will not override most of the denials for the bundled services and/or supply. Please refer to Reimbursement Policy: *Modifier 59*.
 - Editing for this rule is based on CMS, McKesson and Anthem sourcing.
 - Please refer to Reimbursement Policies: Bundled Services and Supplies, Injection and Infusion Administration and Modifier 59 and Sleep Studies and Related Bundled Services and Supplies
- **Place of Service edits** identify the reporting of an inappropriate place of service for a particular procedure, either due to the descriptive verbiage of the code, or due to published CPT coding guidelines which indicate that a specific procedure is not intended to be reported in a certain setting. Please refer to reimbursement policy: *Place of Service*.
- **Multiple Surgery, Bilateral and Multiple Endoscopy Rule** calculations are based on the highest RVU rather than the highest allowed amount effective January 1, 2013 after the ClaimsXten version 4.4 upgrade. New Multiple Endoscopy reductions, less than the standard 50% reduction for subsequent procedures and approximating the CMS logic range from 25 to 35 percent depending on the base code family will also be implemented effective January 1, 2013. Please refer to reimbursement policy: *Multiple and Bilateral Services*.
- **Multiple Diagnostic Imaging** reimbursement rules are applied to the technical component of radiologic procedures that have a Multiple Procedure Indicator (MPI) of four (4) in the multiple procedure column of the CMS NPFSTRVF with the implementation of the ClaimsXten 4.4 upgrade. Please refer to reimbursement policy: *Multiple Diagnostic Imaging Reimbursement*.
- **Durable Medical Equipment (DME)** edits have been added with the ClaimsXten 4.4 upgrade. Please see the new DME reimbursement policy pertaining to the purchase and rental of DME equipment as well as additional billing guidelines required in order for a DME item to be eligible for reimbursement.

ClaimsXten® is a registered trademark of McKesson HBOC.

Clear Claim Connection™

Clear Claim Connection (“CCC”) is an online tool available through Anthem’s provider portal, ProviderAccess, intended to be used for evaluating clinical coding information. CCC will provide information according to the claim editing system logic on the date of the provider’s inquiry, and allows providers to view clinically-based information along with documented source information for approximately two million edits. CCC is not a guarantee of member eligibility or claim payment, and is not date-sensitive for the claim date of service. The RVUs in CCC are the current RVUs which may be different from the RVUs on the date of service of a previously processed claim. While most of our reimbursement policies are loaded in CCC, some are not.

Sources referenced for the CCC online tool include: CPT, CPT Assistant, CPT Coding Symposium, Specialty Society Coding Guidelines and Medicare Guidelines. Not all National Accounts, FEP or Medicare Advantage products utilize the claim editing system logic used in CCC, and not all procedure modifiers impact the pricing or processing of procedures (based on Anthem policy).

To access the CCC online tool, login to our secure provider portal, ProviderAccess. Go to **anthem.com** and click the **Providers** link in the top center of the page. Select **Colorado** from the state drop-down box, and **Enter**. From the **ProviderAccess Login** tout (blue box on the left side of the page), select **Medical** from the drop down list and click on the [login](#) button. Enter your user **name** and **password**. Once logged in, from the **Claims** tab, select the **Clear Claim Connection** link.

Clear Claim Connection™ is a trademark of McKesson.

Modifiers

In certain circumstances, it is appropriate to use modifiers to report services that warrant reimbursement separately from what would usually be expected. **The use of the modifiers, listed below should be reserved for special circumstances prompted by an individual situation involving a specific patient. The use of these modifiers should not be routine.** More information about using modifier 25 and 59 and exceptions to recognition of modifiers 25 and 59 processing guidelines in addition to their separate policies in the “View Reimbursement & Admin Policies” link, is available on our secure provider portal, ProviderAccess. Go to **anthem.com** and click the **Providers** link in the top center of the page. Select **Colorado** from the state drop-down box, and **Enter**. From the **ProviderAccess Login** tout to the (blue box on the left side of the page), select **Medical** from the drop down list and click on the [login](#) button. Enter your user **name** and **password**. Once logged in, from the **Overview** tab, under the **Policies and Procedures** section, select the link titled “**Modifier 25 & 59 Rules**”.

- **Modifier 25** is used to indicate that on the day a procedure or preventive exam was performed, the patient’s condition required a significant, separately identifiable E/M service beyond the usual care associated with the procedure or preventive exam. Without the modifier-25 designation, the E/M code is bundled

into the procedure, or preventive exam. Only append modifier 25 to E/M codes 99201-99499.

- **Routine use of modifier 25 to avoid bundling edits is inappropriate.**
 - **Only use modifier 25 for unique situations as indicated above.**
 - If modifier 25 is appended to inappropriate codes, it will be disregarded. Or denied as inappropriate use of the modifier.
 - When more than one problem oriented E/M service is performed on the same day, only the most clinically intense E/M service should be reported. Effective for claims processed on or after the ClaimsXten 4.4 upgrade implemented on February 16, 2013, modifier 25 will not override the edit for two separate problem oriented E/M services reported on the same date of service by the same provider (or more than one provider of the same specialty in the same provider group).
 - Some screening service codes are included in the reimbursement for other E/M codes when reported together. For more information on Screening Services with E/M services and the use of Modifier 25 please refer to Reimbursement Policy: *Screening Services with Evaluation and Management Services*.
 - For more information on Modifier 25 please refer to Reimbursement Policy: *E/M and Related Modifiers 25 and 57*.
- **Modifier 57** is used to identify the patient encounter that resulted in the decision to perform surgery. Without the modifier, the E/M code is bundled to the surgical procedure when performed the day of or the day before a major surgical procedure.
 - **Modifier 59** is used to identify procedures/services that aren't normally reported together but are appropriate under the circumstances. This may include a different procedure or surgery, a different site, or a separate incision/excision, lesion or patient encounter. Without the modifier 59 designation, bundling may occur. Effective on November 14, 2009, ClaimsXten implemented NCCI edits. Effective May 23, 2010, with the 2nd quarter ClaimsXten update, we are following most "modifier allowed" CMS logic as well. If the "Modifier Allowed" designation for the code pair is zero; modifiers (such as modifier 59) will **not** override the edit (Anthem has made customizations to some code pairs and will not allow modifier 59 to override these customizations.)
 - **Only append modifier 59 to procedures or surgeries.**
 - Modifier 59 is not appropriate for supplies, DME codes, drugs or "J" codes or E/M codes.
 - If modifier 59 is appended to inappropriate codes, it will be disregarded or denied as inappropriate use of the modifier.

- **Routine use of modifier 59 to avoid bundling edits is inappropriate. Only use it in unique situations as indicated above.**
- For more information on Modifier 59 please refer to Reimbursement Policy: *Modifier 59*.
- **Modifier 50** is used to indicate a bilateral procedure. A bilateral procedure is reported on one line with the unilateral surgical procedure code, one unit of service and modifier 50. Bilateral surgeries/procedures are considered one surgery. Effective January 1, 2013, after the ClaimsXten 4.4 upgrade, Anthem will apply the increased allowance of 150% for bilateral procedures to the RVU for the procedure code prior to the applying the multiple surgery reimbursement rules. This higher RVU is used when ranking multiple procedures based on highest RVU to determine which procedure is the primary service and which procedure is the secondary/subsequent service(s). (Claims are processed based on the RVU for the date of service. Because CMS updates their files on a quarterly basis, the RVU for the date of service may be different than the current RVU seen on Clear Claim Connection.) For additional important information about Modifier 50 processing and modifier 50 assumptions, please refer to Reimbursement Policy: *Multiple and Bilateral Surgery*.
- **Additional Modifiers** and their effect on claims processing are included in Reimbursement Policy: *Modifier Rules*.

On-call Coverage for Primary Care Physicians

PCPs are required to provide twenty-four (24) hour coverage, seven (7) days a week, for Anthem members. After-hours coverage may consist of the following:

- A covering physician who is a PCP in the member's designated PCP's clinic or medical management group, in which case a referral isn't necessary
- The covering physician is a Provider with Anthem, and the covering physician's name is in the Anthem system as an on-call provider for the PCP. When an Anthem member sees an on-call provider, claims are processed at the on-call provider's contracted rate with Anthem.

Please forward updated on-call information, in writing, to the Provider File Management address listed in the Customer Service and ProviderAccess section of this Manual.

Resource Based Relative Value Scale

Anthem's fee schedule is based on the CMS Resource Based Relative Value Scale ("RBRVS"). Anthem uses the National conversion factor as its local Medicare conversion factor. Anthem applies the effect of CMS Geographic Practice Cost Indices ("GPCIs") factors to the Relative Value Units ("RVUs"). CPT codes with CMS RVUs, the local Medicare conversion factor for Colorado is multiplied by each CPT code's GPCI'd non-facility and facility RVU to arrive at a local non-facility and facility price.

The RBRVS is based on the resources a physician typically uses for each procedure and service, from physical, intellectual and emotional effort to overhead and training. The following components are used in computing a fee for a given service:

- Physician work
- Practice expense, including office rent, non-physician salaries, capital equipment costs and **supplies**
- Professional liability (malpractice) expense, including the cost of professional liability insurance

The RBRVS method doesn't set unit values for anesthesiology and clinical laboratory procedures. In these instances, Anthem uses ASA relative values for anesthesiology and CMS fees for clinical lab.

Throughout this Manual, Anthem's method of reimbursement will be referred to as the current Anthem fee schedule, which is a combination of the modified RBRVS values, the services not evaluated by RBRVS and the Anthem conversion factor.

[Facility Reimbursement Policies](#)

Changes During Admission

There are elements that could change during an admission. The following table shows the scenarios and the date to be used:

CHANGE	EFFECTIVE DATE
Member's Insurance Coverage	Admission
Facility's Contracted Rate (other than DRG)	Admission
DRG Base Rate	Admission
DRG Grouper	Discharge
DRG Relative Weight	Discharge

Emergency Department Services

Description

The Emergency Department (ED) is a hospital-owned location or department for the provision of unscheduled episodic services to patients who present for immediate medical attention. Services rendered to a patient in the ED usually do not exceed 24 hours.

Emergency Department level of service is determined by the intervention(s) that are performed in relationship to the intensity of medical care required by the presenting symptoms and resulting diagnosis of the patient:

- **Straight Forward Complexity (99281/G0380)**: The presented problem(s) are self-limited or minor conditions with no medications or home treatment required, signs and symptoms of wound infection explained, return to ED if problems develop.
- **Low Complexity (99282/G0381)**: The presented problem(s) are of low to moderate severity. Over the counter (OTC) medications or treatment, simple dressing changes; patient demonstrates understanding quickly and easily.
- **Moderate Complexity (99283/G0382)**: The presented problem(s) are of moderate severity. Head injury instructions, crutch training, bending, lifting, weight-bearing limitations, prescription medication with review of side effects and potential adverse reactions; patient may have questions, but otherwise demonstrates adequate understanding of instructions either verbally or by demonstration.
- **Moderate-High Complexity (99284/G0383)**: The presented problem(s) are of high severity, and *require urgent evaluation* by the physician but do not pose an immediate significant threat to life or physiologic function. Head injury instructions, crutch training, bending, lifting, weight-bearing limitations, prescription medication with review of side effects and potential adverse reactions; patient may have questions, but otherwise demonstrates adequate understanding of instructions either verbally or by demonstration.
- **High Complexity (99285/G0384)**: The presented problem(s) are of high severity and pose an *immediate significant threat* to life or physiologic function. Multiple prescription medications and/or home therapies with review of side effects and potential adverse reactions; diabetic, seizure or asthma teaching in compromised or non-compliant patients; patient/caregiver may demonstrate difficulty understanding instructions and may require additional directions to support compliance with prescribed treatment.

Policy

The payment, if any, for Emergency Department (ED) Services is specified in the Plan Compensation Schedule or Contract. Anthem requires that the patient's medical record documentation for diagnosis and treatment in the ED must indicate the presenting symptoms, diagnoses and treatment plan and requires a written order by the physician clearly documented in the medical record.

A Current Procedural Terminology (CPT) ® Code or a Healthcare Common Procedure Coding System (HCPCS) ® Code for Evaluation and Management (E&M) must be billed for the complexity of service that occurred during the patient encounter at the ED. Anthem defines the complexity level of service for the E&M codes as described in the table in Exhibit A, below.

The table in Exhibit A provides criteria that Anthem will use to determine the level of reimbursement as applicable for ED services. Exhibit A lists the E&M codes and defines the levels. Each level provides procedure and clinical examples that align with the complexity level to assist the facility in understanding the meaning of the descriptors used to define the level of E&M service. The procedure and clinical examples in Exhibit A are not an all-inclusive list. The highest level E&M code for which a claim clinically qualifies will be used to determine the level of reimbursement, as applicable for ED services.

Note: The procedure and clinical examples in Exhibit A are not an all-inclusive list. The highest level E&M code of which a claim clinically qualifies will be used to determine the level of reimbursement, as applicable for ED services.

Exhibit A

CPT® 99281/HCPCS® G0380 Straight Forward Complexity	
The presented problem(s) are self-limited or minor conditions with no medications or home treatment required, signs and symptoms of wound infection explained, return to ED if problems develop.	
Procedure Examples	Clinical Examples
Triage only	Insect bite (uncomplicated)
No medication or treatment	Read Tb test
Wound Check-simple	
Steri-Strip wound	
Booster or follow up immunization--no acute injury	
Dressing change (uncomplicated)	
Prescription refill	
Suture removal (uncomplicated)	

Implants

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

Facility shall not bill Anthem for implants that are deemed contaminated and/or considered waste and/or were not implanted in the Covered Individual. Additionally, Anthem will not reimburse Facility for implants that are deemed contaminated and/or considered waste and/or were not implanted in the Covered Individual.

Interim Bill Claims

Anthem shall not process claims submitted as interim bills for services reimbursed under DRG methodology.

Observation Services Policy

Description

Anthem considers outpatient observation services to mean active, short-term medical and/or nursing services performed by an acute facility on that facility's premises that includes the use of a bed and monitoring by that acute facility's nursing or other staff and are required to observe a patient's condition to determine if the patient requires an inpatient admission to the facility. Observation services include services provided to a patient designated as "observation status", and in general, shall not exceed 24 hours. Observation services may be considered eligible for reimbursement when rendered to patients who meet one or more of the following criteria:

- Active care or further observation is needed following emergency room care to determine if the patient is stabilized.
- The patient has a complication from an outpatient surgical procedure that requires additional recovery time that exceeds the normal recovery time.
- The patient care required is initially at or near the inpatient level; however, such care is expected to last less than a 24 hour time frame.
- The patient requires further diagnostic testing and/or observation to make a diagnosis and establish appropriate treatment protocol.
- The patient requires short term medical intervention of facility staff which requires the direction of a physician.
- The patient requires observation in order to determine if the patient requires admission into the facility.

Policy

The payment, if any, for observation services is specified in the Plan Compensation Schedule or Contract with the applicable Facility. Nothing in this Policy is intended to modify the terms and conditions of the Facility's agreement with Anthem. If the

Facility's agreement with Anthem does not provide for separate reimbursement for observation services, then this Policy is not intended to and shall not be construed to allow the Facility to separately bill for and seek reimbursement for observation services.

The patient's medical record documentation for observation status must include a written order by the physician or other individual authorized by state licensure law and facility staff bylaws to admit patients to the facility that clearly states "admit to observation". Additionally, such documentation shall demonstrate that observation services are required by stating the specific problem, the treatment and/or frequency of the skilled service expected to be provided,"

The following situations are examples of services that are considered by Anthem to be inappropriate use of observation services:

- Physician, patient, and/or family convenience
- Routine preparation and recovery for diagnostic or surgical procedures
- Social issues
- Blood administration
- Cases routinely cared for in the Emergency Room or Outpatient Department
- Routine recovery and post-operative care after outpatient surgery
- Standing orders following outpatient surgery
- Observation following an uncomplicated treatment or procedure

Personal Care Items

Personal care items used for patient convenience are not reimbursable. Examples include but are not limited to: deodorant, dry bath, dry shampoo, lotion, non-medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, toothbrush and toothpaste. Items used for the patient which are needed as a direct result of a procedure or test are considered part of the room and board or procedure charges and are not separately reimbursable or billable to the patient. Examples include but are not limited to: bedpans, chux, hot water bottles, icepacks, pillows, sitz baths, and urinals.

Portable Charges

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

Preparation (Set-Up) Charges

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

Robotic Assisted Surgery

Anthem considers the use of robotic technology to be a technique that is integral to the primary surgery being performed and, therefore, not eligible for separate reimbursement. When billed, there will be no additional payment for charges associated with robotic technology.

Examples of charges that are not eligible for separate or additional reimbursement are listed below.

- Increased operating room unit cost charges for the use of the robotic technology
- Charges billed under CPT or HCPCS codes that are specific to robotic assisted surgery, including, but not limited to, S2900 – (Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure)).

Stand-by Charges

Standby equipment and consumable items such as oxygen, which are on standby, are not reimbursable. Only actual use is covered. Professional staff on standby is included in the reimbursement for the procedure and also is not separately reimbursable.

Stat Charges

Stat charges are included in the reimbursement for the procedure, test and or x-ray. No additional charges for stat services will be allowed.

Test or Procedures Prior to Admission(s) or Outpatient Services

The following diagnostic services, defined by specific Coded Service Identifier(s), are considered part of pre-admission/pre-surgical/pre-operative testing:

- 254 – Drugs incident to other diagnostic services
- 255 – Drugs incident to radiology
- 30X – Laboratory
- 31X – Laboratory pathological
- 32X – Radiology diagnostic
- 341 – Nuclear medicine, diagnostic
- 35X – CT scan
- 40X – Other imaging services
- 46X – Pulmonary function
- 48X –Cardiology
- 53X – Osteopathic services
- 61X – MRI
- 62X – Medical/surgical supplies, incident to radiology or other services

73X – EKG/ECG

74X – EEG

92X – Other diagnostic services

Non-diagnostic services are also considered part of pre-admission/pre-surgical/pre-operative testing if they are furnished in connection with the principal diagnosis that necessitates the outpatient procedure or the member's admission as an inpatient.

Three-Dimensional (3D) Rendering of Imaging Studies

Description

Three-dimensional (3D) rendering of imaging studies uses multiple thin sections of images and reconstructs them into 3 dimensional images which can extract and display anomalies and/or structures to optimize visualization of the pathology. This type of reconstruction may be applied to computed tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), other tomographic studies, or ultrasound (U/S) studies.

3D image reconstructions are rendered post-processing of the initial images under concurrent physician supervision. The reconstructions may take place either on the same scanner the original studies were conducted which has 3D reconstruction built into the imaging software (Current Procedural Terminology (CPT) code 76376) or on an independent workstation at a later time (CPT code 76377).

This policy documents the Health Plan's reimbursement position on 3D rendering of imaging studies.

Policy

The Health Plan considers 3D rendering of imaging studies to be included in the reimbursement for the imaging study performed. The Health Plan considers 3D rendering of imaging studies to be a technology and technique improvement, enabling computer generated real-time interaction with the image volume dataset. Therefore, separate visual enhancements reported with CPT codes 76376 and 76377 are not eligible for separate or additional reimbursement even when billed with modifier -59.

CPT is a registered trade mark of the American Medical Association

Coding

- **76376** – 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; not requiring image post-processing on an independent workstation
- **76377** – requiring image post-processing on an independent workstation

Time Calculation

- Operating Room ("OR") – OR time should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes.
- Anesthesia – Time Charges should be calculated from the start and finish times as documented on the anesthesia record. Anesthesia materials may be charged individually as used or included in a Charge based on time. A Charge that is based on time will be computed from the induction of the anesthesia until surgery is complete. This Charge will include the use of all monitoring equipment. Other types of anesthesia such as local, regional, IV sedation etc., must be billed at an appropriate rate for the lower level of anesthesia services.
- Recovery Room – Time should be calculated from the time the patient enters the recovery room until the patient leaves the recovery room as documented on the post anesthesia care unit ("PACU") record. Post Recovery Room – Time Charges should be calculated from the time the patient leaves the recovery room until discharge.

Undocumented or Unsupported Charges

Per Anthem policy, Plan will not reimburse Charges that are not documented on medical records or supported with reasonable documentation.

Video Equipment used in Operating Room

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

Coordination of Benefits/Subrogation

Coordination of benefits ("COB") refers to the process for members receiving full benefits while preventing double payment for services when a member has coverage from two or more sources. The member's contract outlines which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

Providers and Facilities shall establish procedures for identifying members who have work-related injuries or illnesses or who have other coverage (including auto insurance), that may be coordinated with Anthem coverage. Providers shall use their best efforts to notify Anthem whenever they have reason to believe a member may be entitled to coverage under any other insurance plan, including Medicare, and shall assist Anthem in obtaining COB information when a member holds such other coverage.

Providers and Facilities agree to make their best effort to identify and notify Anthem of any facts that may be related to auto, workers' compensation, or third-party injury or

illness, and to execute and provide documents that may reasonably be required or appropriate for the purpose of pursuing reimbursement or payment from other payers.

This section shall not be construed to require Provider or Facility to waive Cost Shares in violation of any Medicare rule or regulation, nor shall this provision be construed to supersede any other Medicare rule or regulation.

Anthem adjudicates COB claims according to the following guidelines:

- When Anthem is the primary carrier, standard Anthem reimbursement, along with applicable copayments, coinsurance and deductibles, is considered payment in full from Anthem.
- If Medicare is the primary payer, and member has full basic secondary coverage through Anthem (non-Medicare Supplement), Anthem will use the Medicare allowed amount or the limiting amount (if the provider didn't accept Medicare assignment) to determine a secondary payment.
- For PPO and Indemnity claims when Anthem is the secondary carrier and the primary carrier isn't Medicare, the higher of either Anthem's or the primary carrier's allowance will be used to determine a secondary payment.
- For HMO claims when HMO Colorado is the secondary carrier and:
 - **HMO Colorado's reimbursement is capitation:** The provider has already received payment from HMO Colorado, and this payment fulfills HMO Colorado's obligations as a secondary carrier. This payment shall be used to cover the member's obligations under the member's primary coverage, including any copayment or other liabilities. Therefore, the Provider or Facility may not charge the member for any copayment or other liability; if funds are collected from the member, the Provider or Facility must reimburse the member for those charges from the Provider or Facility's capitation payment.
 - **HMO Colorado's reimbursement is non-capitated, i.e., some form of fee-for-service:** When the primary carrier is not Medicare, the higher of either HMO Colorado's or the primary carrier's allowance will be used to determine a secondary payment. At no time will HMO Colorado pay more as the secondary carrier than it would have paid in the absence of another insurance carrier.
 - **Medicare is the primary payer:** HMO Colorado will use the Medicare allowed amount or the limiting amount (if the provider did not accept Medicare assignment) to determine a secondary payment.
- At no time will Anthem pay more as the secondary carrier than it would have paid had it been the primary carrier.

Members with Individual Plan Coverage

Benefit payments for Anthem members with Individual coverage cannot be coordinated with another **commercial** health insurance carrier. However, benefits may be coordinated with workers' compensation, Medicare coverage or third-party, excluding a member's auto medical payments. Before sending Anthem a refund due to duplicate claims payment, please verify that the refund being submitted is for a member with Group – not Individual – coverage.

Coordination of Benefits for BlueCard®

If, after calling 800-676-BLUE or through other means you discover that a member's insurance plan contains a COB provision, and if any Blue Cross and/or Blue Shield plan is the primary payer, please submit the claim(s) along with information about COB to Anthem. If COB information isn't included with the claim, the member's plan or the insurance carrier will have to investigate the claim, which will delay claim processing.

Coordination of Benefits for FEHBP

See the Federal Employee Health Benefits Program

[Eligibility and Payment](#)

A guarantee of eligibility is not a guarantee of payment.

[Copayments/Cost Shares](#)

Providers should only collect copayments/Cost Shares from members at the time services are rendered. Please refer to the member's health plan ID card for copayment/Cost Share information.

Office Visit Copayments

An office copayment is required for **most** office visits for which a provider's office ordinarily generates a charge, including blood pressure checks, regularly scheduled injections and educational sessions with a nutritionist, physical therapist, etc. If a charge isn't generated for a visit, the provider doesn't collect a copayment.

For HMO Colorado members only: Non-surgical diagnostic procedures for which there are no other associated office visit charges are the only services for which a provider doesn't collect an office visit copayment from an HMO Colorado member. Such services include lab work, X-rays, mammograms, audiograms, EKGs, etc. Immunizations and flu shots do not require a copayment if no other office visit charge is associated with these procedures.

Emergency/Urgent Care Copayment

The **emergency care** copayment is collected by the emergency room at an acute care hospital.

The **urgent care** copayment is collected by the PCP's office when:

- The office must disrupt its schedule to see an Anthem member on an urgent care basis during the day; or
- The physician sees the member after hours or during weekend hours when no facility fee is charged.

The **urgent care** copayment is collected when a member is seen at an urgent care center. These amounts are listed on the member's health plan ID card. **For HMO Colorado members only**, the emergency and urgent care copayments most often are the same amount, although in some cases, the copayment amounts will be different.

Inpatient Hospital Copayment

The inpatient hospital copayment is paid to hospitals for inpatient admissions. Payment arrangements can be made between the hospital and the member before an inpatient hospital admission.

[Urgent Care Services](#)

Valid procedure codes must be used when medical services are rendered in the office rather than sending the member to the emergency room in an urgent or emergency situation outside normal office hours.

After-hours care/office services code 99050 may be allowed in addition to the basic service when care is requested outside a provider's normal or published office hours, such as between 10 p.m. and 8 a.m., or services are requested when a provider's office is closed on weekends and holidays.

Code 99051 may be allowed in addition to the basic service when Service(s) are provided in the **office** during regularly scheduled **evening, weekend, or holiday** office hours.

See Reimbursement Policy: *Urgent Care – Coding and Bundled Supplies* for more information.

The applicable deductible, coinsurance and/or co-payment requirements for urgent care services remain in place, and Anthem members are responsible for paying those cost-sharing amounts.

Emergency Services

Benefits for routine or preventive care services provided in the emergency department are not within the meaning of emergency services.

The applicable deductible, coinsurance and/or co-payment requirements for emergency services remain in place, and Anthem members are responsible for paying those cost-sharing amounts.

Preventive Care Services

Preventive care services are covered based on the Colorado state mandates and include:

- Prostate cancer screening
- Child health supervision services
- Cervical cancer vaccines (HPV)
- Preventive health care services:
 - Alcohol misuse screening and behavioral counseling interventions for adults by primary care providers
 - Tobacco use screening of adults and tobacco cessation interventions by primary care providers
 - Cervical cancer screening (pap smear)
 - Breast cancer screening with mammography
 - Cholesterol screening for lipid disorders
 - Colorectal cancer screening
 - Childhood immunizations
 - Influenza vaccinations
 - Pneumococcal vaccinations
 - Maternity

Changes in Preventive Care Benefits Due to Health Care Reform

The new health care reform law (the Patient Protection and Affordable Care Act or “PPACA”) will require Anthem Blue Cross and Blue Shield (Anthem) to cover additional preventive care services and eliminate member cost-sharing (copayments, deductibles, or coinsurance) for certain in-network preventive care services. Cost-sharing requirements for preventive care services rendered out-of-network will continue to apply as they do today.

In general, changes in preventive care benefits for group health plans and group insurance policies administered or issued by Anthem will be effective on the first day of the plan year or the group policy's renewal date on or after September 23, 2010. The changes will be effective for individual policies on the first policy year date on or after September 23, 2010, which in almost all cases will be January 1, 2011. ***There are some exceptions to these dates, and not all plans will be subject to the new preventive care coverage requirements, so providers should continue to verify eligibility and benefits through their normal business processes.***

Health Care Reform Impacts Member Policies Differently

The newly enacted health care reform legislation will be implemented in phases until it is fully effective in 2014. During the implementation process, we will strive to give you important information and clarify how these changes will impact your day to day business with Anthem Blue Cross and Blue Shield (Anthem).

It is important to understand that not all member plans will be required to meet all the coverage requirements of the new health care reform law. Policies that are “grandfathered” are exempt from some of the requirements of health care reform. Conversely, certain changes must be made to all plans, whether they are grandfathered or not.

Because the health care reform provisions are implemented based on the plan or policy issue date, the date that provisions are effective will vary from member to member. The effective date will also be affected by the policy type (group or individual) and other factors. As an example, the provisions that take effect on September 23, 2010 will be implemented for most group policies at the first renewal occurring on or after that date. Individual policies will have effective dates that are based on the policy year date, which is almost always January 1, 2011.

We understand that there may be challenges in understanding when and how provisions apply to specific policies, and we want to help keep your eligibility and benefits process simple. As member coverage is modified to reflect the new benefits associated with health care reform, our systems will be updated to share the most up-to-date benefit information. **It is imperative that providers continue verifying eligibility and benefits for your Anthem patients by accessing our secure Provider portal, ProviderAccess, or by contacting Customer Service at the number on the back of the members Health Plan ID card.**

You can continue to check for new communications about health care reform at [Health Care Reform Notifications and Updates](#) on the provider website. If you have questions about how health care reform will impact you or your patients, you can visit www.healthychat.com to submit these questions. This website is dedicated to helping the public understand the many parts of health care reform.

Voluntary Refund Procedure

If the facility or provider discovers that an overpayment has been made and would like to refund the overpaid amount voluntarily, please send the payment, a completed Provider Refund Adjustment Request (“PRAR”) Form, and all supporting documentation to the address listed below.

Supporting Documentation:

- EOB, Other Carrier EOB, or EOMB
- Duplicate Payment Information
- Corrected Claims or Billing

Send all payments with a completed PRAR Form and all supporting documentation to:

- **For overpayments for Local Plan members and BlueCard members (all alpha prefixes other than R + 8 numerics):**
Overpayment Recovery
P.O. Box 92420
Cleveland, OH 44193
- **For overpayments Federal Employee Program (FEP) members (alpha prefix R + 8 numerics):**
Central Region - CCOA Lockbox
P.O. Box 73651
Cleveland, OH 44193-1177

Note: Please reference the claim number, patient name, member ID number, date of service, billed amount, refund amount, and detailed reason for the refund with all payments.

Provider Refund Adjustment Request (PRAR) Form

The PRAR Form can be downloaded and/or printed from **anthem.com**. Select **Providers**, choose **Colorado** from the state drop-down box and click **Enter**. Click [Download Commonly Requested Forms](#), and then click **Provider Refund Adjustment Request Form**. The form is a Word document that can be completed electronically.

Overpayment Recovery Procedure

Anthem seeks recovery of all excess claim payments from the payee to whom the benefit check is made payable.

The procedure for overpayment recovery for Providers and Facilities involves the following notifications to physicians, hospitals, facilities and other health care professionals:

- Day 1:** Anthem identifies overpayment.
- Day 3:** A letter is sent to the provider requesting overpayment.

If the facility or provider believes the overpayment was created in error, it should contact Anthem in writing. For a claims re-evaluation, send your correspondence to the address indicated on the overpayment notification.

Send all payments with a copy of the overpayment letter and/or a completed Provider Refund Adjustment Request (PRAR) Form to:

- **For overpayments for Local Plan members and BlueCard members (all alpha prefixes other than R + 8 numerics):**
Overpayment Recovery
P.O. Box 92420
Cleveland, OH 44193
- **For overpayments Federal Employee Program (FEP) members (alpha prefix R + 8 numerics):**
Central Region - CCOA Lockbox
P.O. Box 73651
Cleveland, OH 44193-1177

Note: Please reference the claim number, patient name, and member ID# with all payments. Make the payment amount equal to the amount requested on the overpayment letter if possible.

If Anthem doesn't hear from the facility or receive payment within 30 days, the following action is taken:

- Day 30:** A second letter is sent to the provider. This is a final request for payment. The letter indicates that if Anthem doesn't receive payment within 15 days, then the overpayment amount "recovery" is taken out of future claims payments.
- Day 45:** If Anthem doesn't receive payment, the overpayment amount is deducted from claims payments.
- Day 60:** When Anthem determines that recovery isn't feasible, a third letter is sent to the provider.

Day 90: If Anthem doesn't receive payment, a fourth letter is sent to the provider.

Day 110: If Anthem doesn't receive a check for the overpayment, the overpayment is referred to a collection service.

Important Information about the Federal Employees Health Benefits Program

The following information applies to members who:

- Aren't covered by either Medicare Part A (hospital insurance) or Part B (medical insurance), or both.
- Are enrolled in the Blue Cross and/or Blue Shield plan as an annuitant, or as a former spouse or family member covered by the family enrollment of an annuitant or former spouse.
- Aren't employed in a position that confers Federal Employees Health Benefit Program coverage.

If the member isn't covered by Medicare Part A, is age 65 or older and receives care in a Medicare-participating hospital, the law (5 U.S.C. 8904[b]) requires the Blue Cross and/or Blue Shield plan to base payment on an amount equivalent to the amount Medicare would have allowed if the member had Medicare Part A. This amount is called the equivalent Medicare amount. After the Blue Cross and/or Blue Shield plan pays, the law prohibits the hospital from charging the member more for Covered Services than any deductibles, coinsurance or copayment owed by the member under the Blue Cross and/or Blue Shield plan. Any coinsurance the member owes will be based on the equivalent Medicare amount, not the actual charge.

Preventable Adverse Events ("PAEs") Policy

Acute Care General Hospitals (Inpatient)

Three (3) Major Surgical Never Events

When any of the Preventable Adverse Events ("PAEs") set forth in the grid below occur with respect to a Covered Individual, the acute care general hospital shall neither bill, nor seek to collect from, nor accept any payment from the Plan **or** the Covered Individual for such events. If acute care general hospital receives any payment from the Plan or the Covered Individual for such events, it shall refund such payment within ten (10) business days of becoming aware of such receipt. Further, acute care general hospital shall cooperate with Anthem in any Anthem initiative designed to help analyze or reduce such PAEs.

Whenever any of the events described in the grid below occur with respect to a Covered Individual, acute care general hospital is encouraged to report the PAE to the

appropriate state agency, The Joint Commission (“TJC”), or a patient safety organization (“PSO”) certified and listed by the Agency for Healthcare Research and Quality.

Preventable Adverse Event	Definition / Details
1. Surgery Performed on the Wrong Body Part	Any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.
2. Surgery Performed on the Wrong Patient	Any surgery on a patient that is not consistent with the documented informed consent for that patient. Surgery includes endoscopies and other invasive procedures.
3. Wrong surgical procedure performed on a patient	Any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.

CMS Hospital Acquired Conditions (“HAC”)

Anthem follows CMS’ current and future recognition of HACs. Current and valid Present on Admission (“POA”) indicators (as defined by CMS) must be populated on all inpatient acute care Facility Claims.

When a HAC does occur, all inpatient acute care Facilities shall identify the charges and/or days which are the direct result of the HAC. Such charges and/or days shall be removed from the Claim prior to submitting to the Plan for payment. In no event shall the charges or days associated with the HAC be billed to either the Plan or the Covered Individual.

Providers and Facilities (excluding Inpatient Acute Care General Hospitals)

Four (4) Major Surgical Never Events

When any of the Preventable Adverse Events (“PAEs”) set forth in the grid below occur with respect to a Covered Individual, the Provider or Facility shall neither bill, nor seek to collect from, nor accept any payment from the Plan **or** the Covered Individual for such events. If Provider or Facility receives any payment from the Plan or the Covered Individual for such events, it shall refund such payment within ten (10) business days of becoming aware of such receipt. Further, Providers and Facilities shall cooperate with Anthem in any Anthem initiative designed to help analyze or reduce such PAEs.

Whenever any of the events described in the grid below occur with respect to a Covered Individual, Providers and Facilities are encouraged to report the PAE to the appropriate state agency, The Joint Commission (“TJC”), or a patient safety organization (“PSO”) certified and listed by the Agency for Healthcare Research and Quality.

Preventable Adverse Event	Definition / Details
1. Surgery Performed on the Wrong Body Part	Any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.
2. Surgery Performed on the Wrong Patient	Any surgery on a patient that is not consistent with the documented informed consent for that patient. Surgery includes endoscopies and other invasive procedures.
3. Wrong surgical procedure performed on a patient	Any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.
4. Retention of a foreign object in a patient after surgery or other procedure	Excludes objects intentionally implanted as part of a planned intervention and objects present prior to surgery that were intentionally retained.

[Publication and Use of Provider and Facility Information](#)

Provider and Facility agree that Anthem, Plans or its designees may use, publish, disclose, and display information related to demographics, credentialing, affiliations, and transparency initiatives, such as but not limited to Anthem Care Comparison, relating to Provider or Facility for commercially reasonable general business purposes.

Medical Policies and Clinical Utilization Management (“UM”) Guidelines

[Medical Policy](#)

The Medical Policy & Technology Assessment Committee (“MPTAC”) is the authorizing body for medical policy and clinical UM guidelines (collectively, “Medical Policy”), which serve as a basis for coverage decisions. The Office of Medical Policy & Technology

Assessment (“OMPTA”) develops Medical Policy for Anthem. The principal component of the process is the review for development of Medical Necessity and/or investigational policy position statements or clinical indications for certain new medical services and/or procedures or for new uses of existing services and/or procedures. The services include but are not limited to devices, biologics and specialty pharmaceuticals, and behavioral health services.

Medical Policies are intended to reflect the current scientific data and clinical thinking. While Medical Policy sets forth position statements or clinical indications regarding the Medical Necessity of individual services and/or procedures, Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

MPTAC is a multiple disciplinary group including physicians from various medical specialties, clinical practice environments and geographic areas.

Voting membership includes:

- external physicians in clinical practices and participating in networks;
- external physicians in academic practices and participating in networks;
- internal medical directors

Non-voting members include:

- internal legal counsel

MPTAC may designate subcommittees for certain specialty topics, such as by way of example only, hematology/oncology and behavioral health. The subcommittees may include external physicians that are not members of MPTAC, but are in clinical or academic practices and are participating in networks. The subcommittees shall make recommendations to MPTAC on topics assigned to them by MPTAC.

MPTAC voting members and subcommittee members are required to disclose any potential conflicts of interest. In the event that a MPTAC voting member or subcommittee member discloses a conflict of interest, the associated member will not participate in the vote specific to the proposed relevant Medical Policy.

To reach decisions regarding the Medical Necessity or investigational status of new or existing services and/or procedures, MPTAC (and its applicable subcommittees) relies on the Medical Necessity or investigational criteria included in the following policies:

- ADMIN.00004 Medical Necessity Criteria
- ADMIN.00005 Investigational Criteria

In evaluating the Medical Necessity or investigational status of new or existing services and/or procedures the committee(s) may include, but not limit their consideration to, the following additional information:

- electronic literature searches, which are conducted and collated results are provided to the committee members;
- independent technology evaluation programs and materials published by professional associations; such as:
 - Blue Cross Blue Shield Association (BCBSA);
 - technology assessment entities;
 - appropriate government regulatory bodies; and
 - national physician specialty societies and associations.

The committee(s) may also consider the service/procedure being reviewed as a standard of care in the medical community with supporting documentation.

The committee(s) is also responsible for reviewing and authorizing the use of Medical Policy used in making determinations of Medical Necessity or investigational determinations which are developed by external entities (e.g., MCG™ or InterQual® criteria).

Additionally, the medical policy team may seek input from selected experienced clinicians. This process allows MPTAC access to the expertise of a wide variety of specialists and subspecialists from across the United States. These individuals are board certified providers who are identified either with the assistance of an appropriate professional medical specialty society, by activity in a participating academic medical center or by participation in a corporate affiliated network. While the various professional medical societies may collaborate in this process through the provision of appropriate reviewers, the input received represents NEITHER an endorsement by the specialty society NOR an official position of the specialty society. MPTAC uses this information in the context of all other information presented from various sources.

All existing Medical Policies are reviewed at least annually to determine continued applicability and appropriateness and to determine whether there is a need for revision, updated citations, etc. and are re-approved through MPTAC.

Medical Policies developed by MPTAC are communicated throughout the company for inclusion in the benefit package and for implementation of the supporting processes. These communication processes include:

- attendance of key associates at MPTAC meetings;
- teleconferences with and written documentation to medical operations associates, medical directors, claims and network relations associates;

- provision of MPTAC meeting minutes and other relevant documentation to health plan leadership.

Medical Policy decisions affecting our members are reported by our health plans to and reviewed for input by the appropriate physician quality committees, which have the responsibility for reviewing MPTAC activities.

[Medical Policy and Clinical Utilization Management \(“UM”\) Guidelines Distinction](#)

Medical policy and clinical UM guidelines differ in the type of determination being made. In general, medical policy addresses the Medical Necessity of new service and/or procedures and new applications of existing services and/or procedures while clinical UM guidelines focus on detailed selection criteria, goal length of stay (GLOS), or the place of service for generally accepted technologies or services. In addition, medical policies are implemented by all Anthem Plans while clinical UM guidelines are adopted and implemented at the local Anthem Plan discretion.

All medical policies and clinical UM guidelines are publicly available on anthem.com. This provides greater transparency for Providers and Facilities, Covered Individuals and the public in general.

[Medical Policies and Clinical UM Guidelines are posted online at anthem.com](#)

Go to **anthem.com**, select the **Provider** link in top center of the page. Select **Colorado** from drop down list and **enter**. From the **Provider Home** tab, select the **enter** button from the blue box on the left side of page titled “[Medical Policies, Clinical UM Guideline, and Pre-Cert Requirements](#)”. (Please note Medical Policies are now available for Local Plan members as well as BlueCard/Out-of-area members.)

Clinical UM Guidelines for Local Plan members

Clinical UM guidelines published on our website represent the clinical UM guidelines currently available to all health Plans throughout our organization. These guidelines address the medical necessity of existing, generally accepted services, technologies and drugs. Because local practice patterns, claims systems and benefit designs vary, a local Plan may choose whether to implement a particular clinical UM guideline. To view the list of clinical UM guidelines adopted by Colorado, navigate to the Disclaimer page by following the instructions above; scroll to the bottom of the page. Above the “Continue” button, click on the link titled “Specific Clinical UM Guidelines adopted by Anthem Blue Cross and Blue Shield of Colorado.”

Utilization Management

Utilization Management Program

Providers and Facilities agree to abide by the following Utilization Management (“UM”) Program requirements in accordance with the terms of the Agreement and the Covered Individual’s Health Benefit Plan. Providers and Facilities agree to cooperate with Anthem in the development and implementation of action plans arising under these programs. Providers and Facilities agree to adhere to the following provisions and provide the information as outlined below, including, but not limited to:

Preservice Review & Continued Stay Review

- A. Provider and Facility shall ensure that non-emergency admissions and certain outpatient procedures that require Pre-certification/Pre-authorization Request as specified by Plan are submitted for review as soon as possible before the service occurs. Information provided to the Plan shall include demographic and clinical information including, but not limited to, primary diagnosis.
- B. Provider or Facility shall provide confirmation to Anthem UM with the demographic information and primary diagnosis within twenty-four (24) hours or next Business Day of a Covered Individual’s admission for scheduled procedures.
- C. If an Emergency admission has occurred, Provider or Facility shall notify Anthem UM within twenty-four (24) hours of the first Business Day following admission. Information provided to the Plan shall include demographic and clinical information including, but not limited to, primary diagnosis.
- D. Provider or Facility shall verify that the Covered Individual’s primary care physician has provided a referral as required by certain Health Benefit Plans.
- E. Provider and Facility shall comply with all requests for medical information for Continued Stay Review required to complete Plan’s review and discharge planning coordination. To facilitate the review process, Provider or Facility shall make best efforts to supply requested information within twenty-four (24) hours of request.
- F. Anthem specific Pre-certification/Pre-authorization Requirements may be confirmed on the Anthem web site or by contacting customer service.

Medical Policies and Clinical UM Guidelines Link

Please refer to the Links section of this Manual for additional information about Medical Policy and Clinical UM Guidelines.

On-Site Continued Stay Review

If Plan maintains an On-Site Continued Stay Review Program, the Facility's UM program staff is responsible for following the Covered Individual's stay and documenting the prescribed plan of treatment, promoting the efficient use of services and resources, and facilitating available alternative outpatient treatment options. Facility agrees to cooperate with Anthem and provide Anthem with access to Covered Individuals medical records as well as access to the Covered Individuals in performing on-site Continued Stay Review and discharge planning related to, but not limited to, the following:

- Emergency and maternity admissions
- Ambulatory surgery
- Case management
- Pre-admission testing ("PAT")
- Inpatient Services, including Neo-natal Intensive Care Unit ("NICU")
- Focused procedure review

Observation Bed Policy

Please refer to the "Observation Services Policy" located in the Billing and Reimbursement Guidelines section of the Manual.

Retrospective Utilization Management

Retrospective UM is designed to retrospectively review Claims for Health Services in accordance with the Covered Individual's Health Benefit Plan. Medical records and pertinent information regarding the Covered Individual's care are reviewed by nurses (with input by physician consultants when necessary) against available benefits to determine the level of coverage for the Claim, if any. This review may consider such factors as the Medical Necessity of services provided, whether the Claim involves cosmetic or experimental/investigative procedures, or coverage for new technology treatment.

Failure to Comply With Utilization Management Program

Provider and Facility acknowledge that the Plan may apply monetary penalties as a result of Provider's or Facility's failure to provide notice of admission or obtain Pre-service Review on specified outpatient procedures, as required under this Agreement, or for Provider's or Facility's failure to fully comply with and participate in any cost management procedures and/or UM programs.

Case Management

Case Management is a voluntary Covered Individual Health Benefit Plan management program designed to support the use of cost effective alternatives to inpatient treatment, such as home health or skilled nursing facility care, while maintaining or improving the quality of care delivered. The nurse case manager in Anthem's case management program works with the treating physician(s), the Covered Individual and/or the Covered Individual's Authorized Representative, and appropriate Facility personnel to both identify candidates for case management and to help coordinate benefits for appropriate alternative treatment settings. The program requires the consent and cooperation of the Covered Individual, or Covered Individual's Authorized Representative, as well as collaboration with the treating physicians.

A Covered Individual (or Covered Individual's Authorized Representative) may self refer or a Provider or Facility may refer a Covered Individual to Anthem's Case Management program by calling the Customer Service number on the back of the member's ID card.

Utilization Statistics Information

On occasion, Anthem may request utilization statistics for disease management purposes using Coded Services Identifiers. These may include, but are not limited to:

- Covered Individual name
- Covered Individual identification number
- Date of service or date specimen collected
- Physician name and/or identification number
- Value of test requested or any other pertinent information Anthem deems necessary.

This information will be provided by Provider or Facility to Anthem at no charge to Anthem.

Electronic Data Exchange

Facility will support Anthem by providing electronic data exchange including, but not limited to, ADT (Admissions, Discharge and Transfer), daily census, confirmed discharge date and other relevant clinical data.

Reversals

Utilization Management determinations will not be reversed unless;

1. New information is received that is relevant to an adverse determination which was not available at the time of the determination, or;
2. The original information provided to support a favorable determination was incorrect, fraudulent, or misleading.

Quality of care incident

Providers and Facilities will notify Anthem in the event there is a quality of care incident that involves a Covered Individual.

Audits/Records Requests

At any time Anthem may request on-site, electronic or hard copy medical records, utilization review sheets and/or itemized bills related to Claims for the purposes of conducting audits and reviews to determine Medical Necessity, diagnosis and other coding and documentation of services rendered.

UM Definitions

1. **Pre-service Review.** Review for Medical Necessity prior to service delivery.
2. **Continued Stay Review.** Review for Medical Necessity during ongoing inpatient stay in a facility or a course of treatment, including review for transitions of care and discharge planning.
3. **Pre-certification/Pre-authorization Request.** For Anthem UM team to perform Pre-service Review, the provider submits pertinent clinical information as soon as possible to Anthem UM prior to service delivery.
4. **Pre-certification/Pre-authorization Requirements.** List of procedures that require Pre-service Review by Anthem UM prior to service delivery.
5. **Business Day.** Monday through Friday, excluding legal holidays.
6. **Notification.** The telephonic and written communication to the health care professional(s) and the Covered Individual documenting the medical appropriateness decision, and informing the health care professional and Covered Individual of their rights if they disagree with the decision.

Referrals and Pre-certifications

HMO Colorado Referrals

Referrals to in-network specialist are required for some products. If at any time a referral is required for Medically Necessary treatment to an in-network provider a standing referral will be accepted. Although physician specialist office visits may not require a referral, certain in-office services require pre-certification, which providers must obtain by calling the provider pre-certification phone number on the back of the Covered Individual's health plan ID card.

Surgical procedures, select radiology tests, behavioral health care and chemical dependency rehabilitation services also require pre-certification. The Covered Individual

or provider must call Anthem's behavioral health operations at 800-424-4012 to obtain pre-certification or otherwise coordinate those services.

Covered Individuals must select a PCP and are encouraged to continue coordinating all care through their selected PCP.

HMO Colorado Referrals to Non-participating Providers

HMO Colorado Covered Individuals have out-of-network benefits only for urgent and emergency care or for services pre-certified by HMO Colorado. A referral is required for a Covered Individual to see a non-participating specialist (this doesn't apply to HMO Colorado POS Covered Individuals who have out-of-network benefits). HMO Colorado's health case management department staff and/or HMO Colorado's medical director must approve referrals to non-participating providers **before** the services are rendered. Referrals to non-participating providers are appropriate only under the following circumstances:

- There is no provider in the HMO Colorado network, based on access, specialty, distance, appointment wait times, etc., who can reasonably provide the service; or
- Emergency care makes using a non-participating provider necessary.

Emergency care is the only justification for retrospective notification (after 48 hours) about the use of a non-participating provider.

When HMO Colorado provides pre-certification for a Covered Individual to be admitted to a hospital, use the emergency room or have outpatient surgery, all services performed for the Covered Individual during the admission, surgery or emergency room visit, including those services performed by non-participating providers, will be paid in accordance with the Covered Individual's benefits and appropriate reimbursement.

Pre-certifications

Anthem's pre-certification requirements are consolidated in the Pre-certification Quick Reference Guide ("QRG"). The information in the QRG is available at anthem.com. The QRG doesn't replace information in your Agreement or in a Covered Individual's Health Benefit Plan. If you don't find the information you need here, or by checking Availity (multi-payer) or ProviderAccess (Anthem's secure Provider portal), please call the provider pre-certification line phone number on the Covered Individual's health plan ID card.

How to Obtain Pre-certification:

Please have the following information available when you call to request pre-certification:

- Covered Individual's name, identification number, and date of birth

- Diagnosis, scheduled procedure, and date of admission or expected date of service
- Name of the admitting facility
- Names of the Covered Individual's PCP and admitting physician
- The Covered Individual's medical records (Please have them in front of you, because you will be asked specific questions about the Covered Individual's past treatment and ongoing medical condition. In some cases, you may be asked to submit additional information in writing.)

Upon receipt of the pre-certification request, Anthem's medical management department staff will:

- Confirm Covered Individual eligibility as of the date of the call.
- Verify the Covered Individual's insurance coverage.
- Certify a projected length of stay for a **scheduled** admission and assign a pre-certification number.

If the admission is **unscheduled**, Anthem's medical management department staff will designate the case as pending and our utilization review representative will contact the care coordinator at the facility to obtain clinical review so Medical Necessity may be evaluated. Providers will then be notified about the approval or denial. If approved, the pre-certification number and certified number of days will be provided at that time.

General Rules for Pre-certification:

Not all health plans offer the same benefits. Always confirm benefits that may be available for the Covered Individual at the time of service either online through Availity, ProviderAccess or by calling customer service at the phone number on the Covered Individual's health plan ID card. **Please note:** Customer service cannot provide pre-certification for services. Providers still must call the pre-certification line phone number on the Covered Individual's health plan ID card or as listed in the QRG.

Pre-certification, or the requirement for it, is not a guarantee of benefits. Once pre-certification is obtained, to facilitate timely and accurate processing of claims, the ordering provider must verify the Covered Individual's eligibility within two (2) business days before providing services.

For services obtained from non-participating providers, benefits may not be available, Covered Individual financial responsibility may increase or reimbursement to providers may be reduced, depending on the Covered Individual's Health Benefit Plan. If a non-participating provider is delivering services, Anthem strongly advises that the Covered Individual and the non-participating provider call customer service at the phone number on the Covered Individual's health plan ID card to confirm available benefits and to clarify financial responsibility, which may make it possible to avoid any applicable financial penalties.

When should pre-certification occur? In most cases, the ordering physician, who is usually also the treating physician, is responsible for obtaining pre-certification. The provider should make the request before providing services. Failure to obtain timely pre-certification will result in a denial or reduction in available benefits. Pre-certification should occur as follows:

- At least twenty-four (24) hours before an elective admission or outpatient procedure
- Within seventy-two (72) hours of an urgent or emergency admission
- Within seven (7) days of urgent or emergency care or an unanticipated in-office procedure

Once pre-certification is obtained, payment will be based on the provisions of the Covered Individual's Health Benefit Plan pertaining to the calculation of copayments, deductibles and coinsurance. Changes to the procedures billed or the circumstances of the Covered Individual's case may result in a revision to or reversal of the pre-certification.

How to Use the Pre-Certification Quick Reference Guide ("QRG")

When using the QRG, refer to the alpha prefix (the three alpha characters) at the beginning of the Covered Individual's ID number to determine if the QRG applies. The Covered Individual's alpha prefix is on the Covered Individual's health plan ID card.

The QRG doesn't apply to Federal Employee Program ("FEP") members. FEP members are identified by an "R" in front of the member ID number on their health plan ID card. For pre-certification for FEP members, please call the following numbers:

- Medical pre-certification: 800-860-2156
- Behavioral health pre-certification: 800-424-4011, press 1, then dial ext. 7140

Additionally, the QRG doesn't apply to BlueCard members. BlueCard members are identified by all alpha prefixes other than those listed on the Alpha Prefix Reference List. For pre-certification for BlueCard members, please call 800-676-BLUE (2583), or check online at anthem.com to be routed to the member's home plan pre-certification requirements (see details below for information available online).

- Go to **anthem.com**, select the **Provider** link in top center of the page. Select **Colorado** from drop down list and **enter**. From the **Medical Policy, Clinical UM Guidelines, and Pre-cert Requirements** tout (blue box on the left side of the page), click the **enter** button. Select the link titled "**[Pre-certification/Pre-authorization Requirements \(for BlueCard/Out-of-Area Members\)](#)**".

The QRG applies to Providers directly contracted with Anthem. Providers contracted through a medical management group must refer to that group's pre-certification requirements.

The QRG also indicates special pre-certification requirements for specific self-funded employer groups, with group-specific notations in the comments column or in the QRG heading.

The QRG indicates all services that require pre-certification, with the overarching requirement that **all inpatient care must be pre-certified**. The QRG has a column labeled “STANDARD,” which lists all standard pre-certification requirements. Any product with pre-certification requirements that differ from the standard are listed in columns to the right, under “EXCEPTION” with the product name.

If you have questions, please call the provider pre-certification line at the number listed in the QRG or as listed previously for FEP and BlueCard members.

Pre-Certification QRG is available online

Note: The most current Pre-certification QRG is posted online at **anthem.com**:

- Go to **anthem.com**, select the **Provider** link in top center of the page. Select **Colorado** from drop down list and **enter**. From the **Medical Policy, Clinical UM Guidelines, and Pre-cert Requirements** tout (blue box on the left side of the page), click the **enter** button. Select the link titled “[Pre-certification/Pre-authorization Requirements \(for Local Plan Members\)](#)”.

Credentialing

[Credentialing Scope](#)

Anthem credentials the following contracted health care practitioners: medical doctors, doctors of osteopathic medicine, doctors of podiatry, chiropractors, and optometrists providing Health Services covered under the Health Benefits Plan and doctors of dentistry providing Health Services covered under the Health Benefits Plan including oral maxillofacial surgeons.

Anthem also credentials behavioral health practitioners, including psychiatrists and physicians who are certified or trained in addiction psychiatry, child and adolescent psychiatry, and geriatric psychiatry; doctoral and clinical psychologists who are state licensed; master’s level clinical social workers who are state licensed; master’s level clinical nurse specialists or psychiatric nurse practitioners who are nationally and state certified and state licensed; and other behavioral health care specialists who are licensed, certified, or registered by the state to practice independently. In addition, Medical Therapists (e.g., physical therapists, speech therapists and occupational therapists) and other individual health care practitioners listed in Anthem’s Network directory will be credentialed.

Anthem credentials the following Health Delivery Organizations (“HDOs”): hospitals; home health agencies; skilled nursing facilities; nursing homes; free-standing surgical centers; lithotripsy centers treating kidney stones and free-standing cardiac catheterization labs if applicable to certain regions; as well as behavioral health facilities providing mental health and/or substance abuse treatment in an inpatient, residential or ambulatory setting.

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 forty-five (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 chair the CC and serve as a voting member (the Chair of the CC). The CC will include at least two participating practitioners, including one who practices in the specialty type that most frequently provides services to Anthem Covered Individuals and who falls within the scope of the credentialing program, having no other role in Anthem Network Management. The Chair of the CC may appoint additional participating practitioners of such specialty type, as deemed appropriate for the efficient functioning of the CC.

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.

Practitioners and HDOs are notified that they have the right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, the Credentialing staff will contact the practitioner or HDO within thirty (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.

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 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 is building 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 web site 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 certificates <ul style="list-style-type: none">The DEA/CDS 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 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

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 or the appropriate state oversight agency performed within the past 36 months for that HDO.

Recredentialing of HDOs occurs 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 Dept. (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
7. Other internal 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 and/or Healthcare Integrity and Protection Data Bank (“HIPDB”). 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 and the HIPDB Guidebook, the process set forth in the NPDB Guidebook and the HIPDB 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. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he/she provides services to Covered Individuals;
- B. 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 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 for each state; and
- C. Must not be currently debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP.
- D. For MDs, DOs, DPMs and oral & 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 or CFPC) in the clinical specialty or subspecialty for which they are applying which has now expired AND a minimum of ten (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 fifty percent (50%) of the time.
 2. Practitioners meeting one of these three (3) 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.
- E. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission ("TJC"), National Integrated Accreditation for Healthcare Organizations ("NIAHO") or an AOA accredited hospital, or a Network HDO 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 one hundred eighty (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 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 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 for each applicable state.

Initial applicants who have NO DEA/CDS certificate 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 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 certificate is obtained.
- c. The applicant agrees to notify Anthem upon receipt of the required DEA.
- d. Anthem will verify the appropriate DEA/CDS via standard sources.
 - i. The applicant agrees that failure to provide the appropriate DEA within a ninety (90) calendar day timeframe will result in termination from the Network.
 - ii. Initial applicants who possess a DEA certificate 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. If the applicant has applied for additional DEA 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 certificate is obtained,

- (c) The applicant agrees to notify Anthem upon receipt of the required DEA,
 - (d) Anthem will verify the appropriate DEA/CDS via standard sources; applicant agrees that failure to provide the appropriate DEA within a ninety (90) calendar day timeframe will result in termination from the Network,
AND
 - (e) Must not be currently 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 or current use of illegal drugs or abuse of 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 (6) months in the past five (5) years with the exception of those gaps related to parental leave or immigration where twelve (12) month gaps will be acceptable. Other gaps in work history of six to twenty-four (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 (2) years.
- 14. No history of criminal/felony convictions or a plea of no contest;
- 15. A minimum of the past ten (10) years of malpractice case history is reviewed.
- 16. Meets Credentialing Standards for education/training for 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 & 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. a 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 (5) 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 one hundred eighty (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. Current, valid, unrestricted license to practice in each state in which the practitioner provides care to Covered Individuals;
- 6. *No current license probation;
- 7. *License is unencumbered;
- 8. No new history of licensing board reprimand since prior credentialing review;
- 9. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per OIG and OPM Reports or on

NPDB report);

10. Current DEA, CDS Certificate and/or state controlled substance certification without new (since prior credentialing review) history of or current restrictions;
11. 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;
12. No new (since previous credentialing review) history of or current use of illegal drugs or alcoholism;
13. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
14. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
15. 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 (5) years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
16. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
17. 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 (5) 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.
18. No QI data or other performance data including complaints above the set threshold.
 19. Recredentialed at least every three (3) 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 does 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 (3) 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 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.
2. Licensed professional counselor ("LPC") and marriage and family therapist ("MFT") or other master level license type:
 - a. Master's or doctoral degree in counseling, marital and family

therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.

- b. Master or doctoral degrees in divinity do not meet criteria as a related field of study.
- c. Graduate school must be accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, Council for Accreditation of Counseling and Related Educational Programs (“CACREP”), or Commission on Accreditation for Marriage and Family Therapy Education (“COAMFTE”) listings. The institution must have been accredited within three (3) years of the time the practitioner graduated.
- 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 criteria this doctoral program must either be accredited by the APA or be regionally accredited by the CHEA. In addition, a doctoral degree in one of the fields of study noted above 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 (3) 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 Certificate, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA Certificate, the appropriate CDS Certificate is required. The DEA/CDS 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 (3) 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 (1) 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 (5) years experience practicing neuropsychology at least ten (10) hours per week

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 or the Appropriate state oversight agency performed 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 (3) 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 debarred or excluded from participation in any of the following programs: Medicare, Medicaid, or FEHBP.
4. Liability insurance acceptable to Anthem.
5. If not appropriately accredited, HDO must submit a copy of its CMS or state site 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:

MEDICAL FACILITIES

Facility Type (MEDICAL CARE)	Acceptable Accrediting Agencies
Acute Care Hospital	TJC, HFAP, NIAHO, CIQH, CTEAM
Ambulatory Surgical Centers	TJC, HFAP, AAPSF, AAAHC, AAAASF, IMQ
Free Standing Cardiac Catheterization Facilities	TJC, HFAP (may be covered under parent institution)
Lithotripsy Centers (Kidney stones)	TJC
Home Health Care Agencies	TJC, CHAP, ACHC, CTEAM
Skilled Nursing Facilities	TJC, CARF, BOC Int'l
Nursing Homes	TJC, BOC Int'l

BEHAVIORAL HEALTH

Facility Type (BEHAVIORAL HEALTH CARE)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	TJC, HFAP, NIAHO, CTEAM
Residential Care—Psychiatric Disorders	TJC, HFAP, NIAHO, CARF, COA
Partial Hospitalization/Day Treatment—	TJC, HFAP, NIAHO, CARF, for programs

Psychiatric Disorders	associated with an acute care facility or Residential Treatment Facilities.
Intensive Structured Outpatient Program— Psychiatric Disorders	TJC, HFAP, NIAHO, COA, for programs affiliated with an acute care hospital or health care organization that provides psychiatric services to adults or adolescents; CARF if program is a residential treatment center providing psychiatric services.
Acute Inpatient Hospital—Chemical Dependency/Detoxification and Rehabilitation	TJC, HFAP, NIAHO
Acute Inpatient Hospital—Detoxification Only Facilities	TJC, HFAP, NIAHO
Residential Care—Chemical Dependency	TJC, HFAP, NIAHO, CARF, COA
Partial Hospitalization/Day Treatment— Chemical Dependency	TJC, NIAHO, for programs affiliated with a hospital or health care organization that provides drug abuse and/or alcoholism treatment services to adults or adolescents; CHAMPUS or CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents.
Intensive Structured Outpatient Program— Chemical Dependency	TJC, NIAHO, COA, for programs affiliated with a hospital or health care organization that provides drug abuse and/or alcoholism treatment services to adults or adolescents; CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents.

Standards of Participation

[Become a contracted Provider or Facility](#)

To learn more about becoming a [contracted](#) Provider or Facility, view the steps in the provider application process and download the forms you'll need to apply online. Go to **anthem.com**, select the **Provider** link in top center of the page. Select **Colorado** from drop down list and **enter**. From the **Provider Home** tab, select the link titled [Become an Anthem Blue Cross and Blue Shield Provider](#).

Anthem contracts with many types of providers that do not require formal credentialing. However, to become a [contracted](#) Provider or Facility, certain standards of participation still must be met. In addition to the insurance requirements listed in the Legal and Administrative Requirements section of this manual, the chart below outlines requirements that must be met in order to be considered for contracting as a [contracted Ancillary](#) Provider or Facility in one of these specialties:

Provider	Standards of Participation
Ambulance (Air & Ground)	Medicare Certification
Ambulatory Infusion Suites	JCAHO, CHAP or ACHC State & Pharmacy Licensure
Home Infusion Providers	JCAHO, CHAP or ACHC State & Pharmacy Licensure
Clinical Reference Laboratories	CLIA Certification Medicare Certification
Durable Medical Equipment	JCAHO, CHAP, ACHC Medicare Certification Medicinal Gas License
Hearing Aid Supplier	State Licensure
Home Infusion	JCAHO, CHAP, ACHC State & Pharmacy Licensure
Hospice	Medicare Certification
Orthotics & Prosthetics	JCAHO, CHAP, ABC or BOC (Ocularist: NEBU Preferred) Medicare Certification
Dialysis Facilities	Medicare Certification

**Please note: This is only a representative listing of provider types that do not require formal credentialing. If you have questions about whether you are subject to the formal credentialing process or the applicable standards of participation for your provider type, please contact your provider contracting representative.*

Quality Improvement Program

[Quality Improvement Program Overview](#)

“Together, we are transforming health care with trusted and caring solutions.”

We believe health care is local, and Anthem has the strong local presence required to understand and meet customer needs. Our plans are well-positioned to deliver what customers want: innovative, choice-based products; distinctive service; simplified transactions; and better access to information to assist them in seeking quality care. Our local plan presence and broad expertise create opportunities for collaborative programs that reward physicians and hospitals for clinical quality and excellence. Our commitment to health improvement and care management provides added value to customers and health care professionals – helping improve both health and health care costs for those Anthem serves. Anthem takes a leadership role to improve the health of our communities and is helping to address some of health care’s most pressing issues.

- The Quality Improvement (“QI”) Program Description defines the quality infrastructure, establishes program goals/objectives, and describes functional areas that support quality improvement strategies.
- Annually, a QI Work Plan is developed and implemented with the goal of improving the level of service and care provided to Covered Individuals. Anthem also reflects ongoing progress on priority QI metrics.
- The QI Evaluation assesses the overall effectiveness of the quality program, outcomes of the QI metrics defined on the QI Work Plan, and determines if the program goals and objectives were met.

To see a summary of Anthem’s QI Program and most current outcomes, visit us online. Go to anthem.com, and select the **Providers** link at the top of the landing page (under the “Other Anthem Websites” section). Select your **state** from drop down list and **enter**. On the Provider Home page, under the **Health & Wellness** tab (on the blue toolbar) select **Quality Improvement and Standards**, then the link titled “[Quality Improvement Program](#).”

Goals and Objectives

The following program goals and objectives have been adopted to support Anthem's vision and values and to promote continuous improvement in quality care, patient safety and quality of service to our Covered Individuals and Providers and Facilities.

As part of the QI Program, initiatives in these major areas include, but are not limited to:

Quality and Safety of Clinical Care

- *Chronic Disease and Prevention:* Anthem focuses on Covered Individual and/or Provider/Facility outreach for chronic conditions like asthma, heart disease, diabetes and COPD and for preventive health services such as immunizations and cancer screenings. Improvements in these areas result in improved clinical measures such as HEDIS[®] (Healthcare Effectiveness Data and Information Set).
- *Behavioral Health Programs:* Anthem focuses on improving the coordination between medical and behavioral health care, with programs specifically addressing conditions such as alcohol and other drug use, depression, attention deficit hyperactivity disorder, and bipolar disorder.
- *Patient Safety:* Anthem works with physicians, hospitals, and other healthcare providers to help reduce adverse health care-related events and unnecessary cost of care, as well as to develop innovative programs to encourage improvements in quality and safety. Priority areas include medication safety, radiation safety, surgical safety, infection control, patient protection, patient empowerment, care management, and payment innovation.
- *Continuity and Coordination of Care:* Anthem's goal is to help improve continuity and coordination of care across physicians and other health care professionals through interventions that promote timely and accurate communication.

Service Quality

Anthem periodically surveys its Covered Individuals and uses other tools to assess the quality of care and service provided by our network providers and practitioners. We also strive to provide excellent service to our Covered Individuals and Providers and Facilities. Anthem analyzes trends to identify service opportunities and recommends appropriate activities to address root causes.

Patient Safety

Patient safety is critical to the delivery of quality health care. Our goal is to work with physicians, hospitals and other health care Providers and Facilities to promote and encourage patient safety and to help reduce medical errors through the use of guidelines and outcomes-based medicine and promotion of the use of processes and systems aimed at reducing errors. Specifically, support will be provided for the medical

and behavioral health care of our Covered Individuals through collaborative efforts with physicians and hospitals that include incentives based on quality metrics, public reporting of safety information to employers, Providers, Facilities, and Covered Individuals to emphasize the importance of programs to reduce medical errors, and empowering consumers with information to make informed choices. Improving patient safety is dependent upon not only patient needs, but also upon informed patients and the global health care community's demand for respect and attention to clinical outcomes-based practices.

Continuity and Coordination of Care

Anthem encourages communication between all physicians, including primary care physicians (PCPs) and medical specialists, as well as other health care professionals who are involved in providing care to Anthem Covered Individuals. Please discuss the importance of this communication with each Covered Individual and make every reasonable attempt to elicit his or her permission to coordinate care at the time treatment begins. HIPAA allows the exchange of information between Covered Entities for the purposes of Treatment, Payment and Health Care Operations.

The Anthem Quality Improvement (QI) program is an ongoing, and integrative program, which features a number of evaluative surveys and improvement activities designed to help ensure the continuity and coordination of care across physician and other health care professional sites, and to enhance the quality, safety, and appropriateness of medical and behavioral health care services offered by network Providers. These programs currently include:

- **Journey Forward program** (developed by a **collaborative** among Anthem's Parent Company, UCLA's Cancer Survivorship Center, the National Coalition for Cancer Survivorship, the Oncology Nursing Society, and Genentech) is directed at enhancing physician understanding of the late effects of cancer treatment and survivorship and promoting the use of *Survivorship Care Plans* (documents that include a treatment summary and guidance for follow-up care post cancer treatment) for cancer survivors through an educational campaign targeting Covered Individuals and Providers. This is a part of the broader goal to improve the long-term care for cancer survivors by enhancing the continuity and coordination of care between primary and oncology care Providers that are both frequently visited by cancer survivors for follow-up care.
- **The Controlled Substances Utilization Program** alerts physicians about Covered Individuals who are their patients who have ≥ 10 claims for controlled substances in a 90-day period and includes a list of the Covered Individuals' controlled substance prescriptions and prescribing physician to help make sure care is being appropriately coordinated. The information provided to the physician is intended to complement his or her direct knowledge of the Covered Individual, allowing an increased opportunity to evaluate appropriateness of drug therapy, discontinue drug therapy that may no longer be necessary, coordinate

drug therapy with other Providers and help detect potentially fraudulent prescriptions or prescription use.

- **The Polypharmacy Program** identifies Covered Individuals who have filled prescriptions for medications in ten or more therapeutic classes from three or more unique prescribers within a three month period and aims to help reduce injury and adverse events due to polypharmacy drug use. Key features of the Polypharmacy Program include messaging to Providers about Covered Individual polypharmacy utilization and significant drug-drug interactions.
- **Surveys to Assess Coordination of Care.** Anthem conducts a survey with PCPs regarding their satisfaction with the quality and timeliness of communication from hospitals, specialists, home health agencies, outpatient laboratories, and behavioral health providers. Behavioral health providers are also surveyed regarding satisfaction with care management, claims, customer service, and communication and coordination of care between PCPs and other behavioral health providers.
- **Comorbid Medical Behavioral Health (COMB) Program.** The program is an Anthem company-wide core offering within Medical Case Management (CM) and Disease Management (DM). It is an integrated case and disease management program offering a fluid approach to dealing with the complex comorbid medical and behavioral health needs of Covered Individuals and their families along the continuum of care. Medical CM and DM teams route cases that screen positive for depression or have other behavioral health needs to the COMB program. The COMB team assesses Covered Individual needs and then provides education, identifies treatment resources, creates links with behavioral health services, provides support for medication and treatment compliance and offers overall support to Covered Individuals in managing their behavioral health issues. Coordination and continuity of care among all medical and behavioral health providers is encouraged. There is also a targeted Maternal Depression Program for prenatal and post-partum Covered Individuals.
- **Antidepressant Medication Management Program.** In support of appropriate clinical practice, Anthem has this member-focused intervention to promote optimal use of antidepressant medications. All Anthem Covered Individuals who newly start an antidepressant medication receive an individualized educational mailing and a telephone call utilizing automated voice recognition (IVR) technology. The IVR call encourages Covered Individuals to stay on their medication, and if they have questions or concerns, they are directed to the prescribing physician. For Covered Individuals who are more than seven (7) days late in refilling their antidepressant medication, a late refill IVR reminder call is made.

[Continuity of Care/Transition of Care Program](#)

This program is for Covered Individuals when their Provider or Facility terminates from

the network and new Covered Individuals (meeting certain criteria) who have been participating in active treatment with a provider not within Anthem's network. Anthem makes reasonable efforts to notify Covered Individuals affected by the termination of a Provider or Facility according to contractual, regulatory and accreditation requirements and prior to the effective termination date. Anthem also helps them select a new Provider or Facility.

Anthem will work to facilitate the Continuity of Care/Transition of Care (COC/TOC) when Covered Individuals, or their covered dependents with qualifying conditions, need assistance in transitioning to Providers or Facilities. The goal of this process is to minimize service interruption and to assist in coordinating a safe transition of care. Completion of Covered Services may be allowed at an in-network benefit and reimbursement level with an out-of-network provider for a period of time, according to contractual, regulatory and accreditation requirements, when necessary to complete a course of treatment and to arrange for a safe transfer to an in-network Provider or Facility.

Completion of Covered Services by a Provider or Facility whose contract has been terminated or not renewed for reasons relating to medical disciplinary cause or reason, fraud or other criminal activity will not be facilitated.

Covered Individuals may contact Customer Care to get information on Continuity of Care/Transition of Care.

[Quality – In – Sights®: Hospital Incentive Program \(Q-HIP®\)](#)

The Quality-In-Sights®: Hospital Incentive Program (Q-HIP®) is our performance-based reimbursement program for hospitals. The mission of Q-HIP is to help improve patient outcomes in a hospital setting and promote health care value by financially rewarding hospitals for practicing evidence-based medicine and implementing best practices. Q-HIP strives to promote improvement in health care quality and to raise the bar by moving the bell shaped “quality curve” to the right towards high performance.

Q-HIP measures are credible, valid, and reliable because they are based on measures developed and endorsed by national organizations which may include:

- American College of Cardiology (ACC)
- Center for Medicare and Medicaid Services (CMS)
- Institute for Healthcare Improvement (IHI)
- National Quality Forum (NQF)
- The Joint Commission (JC)
- The Society of Thoracic Surgeons (STS)

In order to align Q-HIP goals with national performance thresholds, the Q-HIP benchmarks and targets are based on national datasets such as the Centers for Medicare and Medicaid Services' Hospital Compare database. The measures can be

tracked and compared within and among hospital[s] for all patient data – regardless of health plan carrier.

Annual meetings are held with participating hospitals from across the country, offering participants an opportunity to share feedback regarding new metrics and initiatives. Additionally, a National Advisory Panel (NAP) was established in 2009 to provide input during the scorecard development process. The NAP is made up of patient safety and quality leaders from health systems and academic medical centers from across the country and offers valuable advice and guidance as new measures are evaluated for inclusion in the program.

Hospitals are required to provide Anthem with data on measures outlined in the Q-HIP Manual. Q-HIP measures are based on commonly accepted indicators of hospitals' quality of care. Network hospitals will receive a copy of their individual scorecard which shows their performance on the Q-HIP measures.

[Performance Data](#)

Provider/Facility Performance Data means 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 Healthcare Effectiveness Data and Information Set (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). Provider/Facility Performance Data may be used for multiple Plan programs and initiatives, including but not limited to:

- **Reward Programs** – Pay for performance (P4P), pay for value (PFV) and other results-based reimbursement programs that tie Provider or Facility reimbursement to performance against a defined set of compliance metrics. Reimbursement models include but are not limited to shared savings programs, enhanced fee schedules and bundled payment arrangements.
- **Recognition Programs** – Programs designed to transparently identify high value Providers and Facilities and make that information available to consumers, employers, peer practitioners and other healthcare stakeholders.

[Health Promotion and Wellness](#)

Online Health Information

An online health information service, MyHealth@Anthem powered by WebMD®, is available at anthem.com to all Anthem members, employers, Providers and Facilities and website visitors. It offers valuable tools, such as access to health information in English and Spanish, an easy-to-use health assessment tool, in-depth condition

centers, and a variety of mini quizzes and health trackers. All content is physician-reviewed for medical accuracy.

Collaboration with the Colorado Immunization Information System

In January 2004, Anthem began participating in the Colorado Immunization Information System ("CIIS"), which is a computerized information system operated by the University of Colorado Health Sciences Center on behalf of the Colorado Department of Public Health and Environment ("CDPHE") under the Colorado Immunization Act. CIIS helps Colorado health care providers collect vaccination histories to help ensure correct and timely immunizations for children. Anthem is participating by sending claims information about immunizations to CIIS, where that information is uploaded and integrated into each child's record.

The CIIS helps physicians in providing quality patient care by displaying recommended immunizations at each visit based on current Advisory Committee on Immunization Practices ("ACIP") standards, highlighting reactions and contraindications, producing labels for mailing immunization reminders to patients, and immediately identifying patients for vaccine recalls.

The database is web-enabled and, with no fee, may be accessed using Internet Explorer 5.5 or higher. Providers must sign a user agreement with CIIS and obtain an ID and password. Participating immunization providers may input and retrieve patient immunization data twenty-four (24) hours a day, seven (7) days a week, including retrieving immunization information about new patients entered by other offices. Providers also may print immunization forms for school, day care and camp without pulling charts, and track vaccine usage. Immunizations for a child are kept in a single record, even if the child is seen by more than one provider. CIIS allows a provider to review a patient's immunization history at each visit and quickly determine what immunizations are due, based on ACIP recommendations. CIIS participation is voluntary for providers and parents, and parents may have their child's immunization data excluded. CIIS provides the forms a provider needs to inform a parent of the right to exclude the information and of the benefits of having the child's immunization information in the system.

The Immunization Act allows CIIS to gather immunization information from the child's immunization provider, clinics, schools, the child's parent, the child, the managed care organization or health insurer with which the child is enrolled, and hospitals or entities contracted with the CDPHE under the Immunization Act. Information in the CIIS may only be released to those entities that provide information, plus the Colorado Department of Health Care Policy and Financing for children enrolled in Medicaid. Under the Immunization Act, any person releasing information from the CIIS to another individual not permitted to have such information is committing a crime and may be punished.

HIPAA regulations state that a covered entity may release immunization information without prior authorization to an immunization information system authorized by a state

law such as the Immunization Act. The covered entity must keep track of all releases of protected health information. CIIS keeps a complete record of all information needed to comply with the HIPAA tracking requirements and will furnish a report to a participating immunization provider at no cost.

For more information, please call the CIIS at 303-724-1074 or 888-611-9918.

[Medical Record Standards](#)

Anthem recognizes the importance of medical record documentation in the delivery and coordination of quality care. Anthem has medical record standards that require Providers and Facilities to maintain medical records in a manner that is current, organized, and facilitates effective and confidential medical record review for quality purposes.

For more information on Medical Record standards, please visit our website. Go to **anthem.com**, select the **Provider** link in top center of the page. Select **Colorado** from drop down list and **enter**. From the **Health and Wellness** tab, select [Quality Improvement and Standards](#), then scroll down to “**Medical Record Review**”.

[Member Quality of Care \(“QOC”\) Investigations](#)

The quality management department develops, maintains and implements policies and procedures for identifying, reporting and evaluating potential quality of care/service concerns or sentinel events involving Anthem members. This includes cases reviewed as the result of a grievance submitted by a member and high-risk cases reviewed as the result of a referral received by an Anthem clinical associate. All Anthem associates who may encounter clinical care/service concerns or sentinel events are informed of these policies. Criteria are developed to indicate which cases require referral to a medical director. Based on review by a medical director, QOC cases may be elevated to the regional peer review committee for second level peer review; which may result in referral to the appropriate Credentials Committee. The quality management committee annually reviews these cases for trends and improvement opportunities. The quality council reviews these trends annually during the process of prioritizing quality improvement activities for the subsequent year.

Quality issues are generally investigated by requesting medical records and/or a response from the involved provider or medical group. After reviewing the circumstances of the case, a clinical associate in collaboration with the medical director or his or her designee, may determine that a quality of care/service concern or sentinel event **does not** exist. If that occurs, the case is closed with a severity level 0 for tracking and trending. If the case is a member grievance, the member is sent a resolution letter within thirty (30) calendar days of Anthem’s receipt of the grievance. The member is informed that peer review statutes do not permit disclosure of the details and outcome of the quality investigation. Cases reviewed with “no quality of care issue” identified will be trended at least annually for review by the credentialing committee.

The medical director and/or the regional peer review committee will determine the severity level of a member quality of care/service or sentinel event. In certain circumstances, a clinical peer review may be needed for specialty consultation. Upon completion of the review, the quality management associate will send a letter to the provider explaining the outcome of the review and requesting the provider's response to an identified quality concern. In addition, the provider is advised that the credentialing committee will review trends/patterns per calendar year for its corrective action recommendations. Trends/patterns of all assigned severity levels are reviewed with the medical director and credentialing committee for intervention and corrective action planning. As part of the credentialing/re-credentialing process, the quality management associate will submit any clinical quality of care/service cases or sentinel events to the credentialing committee for review. The quality management clinical associate will submit clinical quality of care/service or sentinel events to medical management groups to whom credentialing has been delegated for their credentialing/re-credentialing review.

Severity Levels for Quality Assurance

Quality of Care ("QOC"):

Level	Points Assigned	Leveling Description
C-0	0	No QOC issue found to exist.
C-1	0	Predictable/unpredictable occurrence within the standard of care. Recognized medical or surgical complication that may occur in the absence of negligence and without a QOC concern.
C-2	5	Communication, administrative, or documentation issue that adversely affected the care rendered.
C-3	5	Failure of a practitioner/provider to respond to a member grievance regarding a clinical issue despite two requests per internal guidelines.
C-4	10	Mild deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be mildly beneath the standard of care.
C-5	15	Moderate deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be moderately beneath the standard of care.
C-6	25	Significant deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be

Level	Points Assigned	Leveling Description
		significantly beneath the standard of care.

Quality of Service

Level	Points Assigned	Leveling Description
S-0	0	No quality of service or Administrative issue found to exist.
S-1	0	Member grievances regarding practitioner's office: physical accessibility, physical appearance, adequacy of the waiting-room and examining-room space, handicap access and record keeping; for tracking and trending. {CR-5}
S-2	5	Communication, administrative, or documentation issue with no adverse medical effect on member.
S-3	5	Failure of a practitioner/provider to respond to a member grievance despite two requests per internal guidelines.
S-4	5	Confirmed discrimination, confirmed HIPAA violation, confirmed confidentiality and/or privacy issue.

Trend Threshold

The following accumulation of QOC and QOS cases with severity levels and points, or any combination of cases totaling 20 points or more during a rolling 12 months will be subject to trend analysis:

- 8 cases with a leveling of C-0 and S-0
- 4 cases with a leveling of C-1
- 4 cases with a leveling of C-2 and S-2
- 4 cases with a leveling of C-3 and S-3
- 2 cases with a leveling of C-4
- 2 cases with a leveling of C-5
- 1 case with a leveling of C-6 (automatic referral to the applicable Peer Review Committee)
- 3 cases with a leveling of S-1 (for a specific office location in a 6 month period)
- 4 cases with a leveling of S-4 (automatic referral to the applicable Provider Review Committee)

A rolling 12 month cumulative level report is generated monthly and reviewed by a G&A clinical associate for trend identification. Complaints against the Health Plan and any of

its processes are also reviewed by report for trend identification. (Four similar complaints constitute a trend).

An analysis is completed by the G&A clinical associate and forwarded to the Medical Director to determine if there is a pattern among the cases. For example, a provider who repeatedly fails to return phone calls to postoperative patients resulting in the potential for or an actual adverse outcome. The Medical Director will determine if further action is warranted, such as the need for a corrective action plan, or referral to the appropriate committee for further review and action, as appropriate.

Corrective action plans received for provider quality of service issues are reviewed by a Medical Director and may be forwarded to the applicable Provider Review Committee if indicated by the Medical Director.

Corrective action plans received for quality of care issues are reviewed by the Medical Director and may be forwarded to the applicable regional Peer Review Committee for further review and follow up, as appropriate.

A written corrective action plan may be required from a provider who meets the above trend threshold or for whom a clinical quality of care/service or sentinel event has been found. A complete corrective action plan must include the following standard elements:

- Mutually agreeable and achievable actions to be taken by the provider
- Specific time periods during which the provider will take the stipulated actions
- Specific measures by which the provider will be evaluated and dates or times on which the evaluation(s) will occur
- A corrective action plan report submitted to the credentialing committee by the quality management/UM clinical liaison at its next scheduled meeting

Anthem's quality management team will review all corrective action plans. If this review indicates the corrective action plan is unacceptable, Anthem's quality management medical director will review the plan. If the medical director agrees that the corrective action plan is inadequate, it will be returned to the provider with comments on the elements needed for an adequate corrective action plan before the provider resubmits the plan. Actions required to be taken as part of a corrective action plan may include, but are not limited to, sanctions, continuing education and in-depth practice monitoring with specific timeframe requirements.

A provider who does not submit the corrective action plan by the deadline or who does not comply with the terms of the corrective action plan will be referred to the Credentialing Committee for further action, which may include termination from the network.

Conflict of Interest

Providers participating in Anthem's quality management program may not review a case in which the provider has a conflict of interest. Conflicts of interest may be personal or financial in nature. Examples of personal conflicts of interest include, but are not limited to, cases in which the reviewer has been the attending or consulting physician or when a family relative or friend is involved. Financial conflicts may occur when the reviewer has relationships or investments in particular health care facilities or treatment modalities.

Additional Information on Anthem Quality Improvement Programs

Additional information on Anthem's Quality Improvement programs can be found on anthem.com. Select the **Providers** link at the top of the landing page (under the "Other Anthem Websites" section). Select your **state** from drop down list and **enter**. On the Provider Home page, under the **Health & Wellness** tab (on the blue toolbar) select "[Quality Improvement and Standards](#)".

Overview of HEDIS®

HEDIS® (*Healthcare Effectiveness Data and Information Set*) is a set of standardized performance measures used to compare the performance of managed care plans and physicians based on value rather than cost. HEDIS is coordinated and administered by NCQA and is one of the most widely used set of health care performance measures in the United States. Anthem's HEDIS Quality Team is responsible for collecting clinical information from Provider offices in accordance with HEDIS specifications. Record requests to Provider offices begin in early February and Anthem requests that the records be returned within 5 business days to allow time to abstract the records and request additional information from other Providers, if needed. Health plans use HEDIS data to encourage their contracted providers to make improvements in the quality of care and service they provide. Employers and consumers use HEDIS data to help them select the best health plan for their needs. For more information on HEDIS go to the "Provider" home page at anthem.com. Click on the "**Provider**" link at the top of the landing page (under the "Other Anthem Websites" section). Select **Colorado** from the drop down list and click **enter**. On the Provider home page under the **Health and Wellness** tab (on the blue toolbar), select the [Quality Improvement and Standards](#) link, then scroll down to "**HEDIS Information**".

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

Overview of CAHPS®

CAHPS® (Consumer Assessment of Healthcare Providers and Systems) surveys represent an effort to accurately and reliably capture key information from Anthem's Covered Individuals about their experiences with Anthem's health plans in the past year. This includes Covered Individual's access to medical care and the quality of the services provided by Anthem's network of Providers. Anthem analyzes this feedback to identify issues causing Covered Individual dissatisfaction and works to develop effective interventions to address them. Anthem takes this survey feedback very seriously.

Health Plans report survey results to NCQA, who uses these survey results for the annual accreditation status determinations and to create National benchmarks for care and service. Health Plans also use CAHPS® survey data for internal quality improvement purposes.

Results of these surveys are shared with Providers annually via “*Network Update*” newsletters, so they have an opportunity to learn how Anthem Covered Individuals feel about the services provided. Anthem encourages Providers to assess their own practice to identify opportunities to improve patients' access to care and improve interpersonal skills to make the patient care experience a more positive one.

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

Clinical Practice Guidelines

Anthem considers clinical practice guidelines to be an important component of health care. Anthem adopts nationally recognized clinical practice guidelines, and encourages physicians to utilize these guidelines to improve the health of our Covered Individuals. Several national organizations produce guidelines for asthma, diabetes, hypertension, and other conditions. The guidelines, which Anthem uses for quality and disease management programs, are based on reasonable medical evidence. We review the guidelines at least every two years or when changes are made to national guidelines for content accuracy, current primary sources, new technological advances and recent medical research.

Providers can access the up-to-date listing of the medical, preventive and behavioral health guidelines through the Internet. To access the guidelines, go to **anthem.com**. Click on the “**Provider**” link at the top of the landing page (under the “Other Anthem Websites” section). Select your **state** and click **enter**. On the Provider Home page, under the **Health and Wellness** tab (on the blue toolbar) select or scroll to **Practice Guidelines**, then select the link titled “[Clinical Practice Guidelines](#)”.

With respect to the issue of coverage, each Covered Individual should review his/her Certificate of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. The Certificate of Coverage and/or Schedule of Benefits supersede the clinical practice guidelines.

Preventive Health Guidelines

Anthem considers prevention an important component of health care. Anthem develops preventive health guidelines in accordance with recommendations made by nationally recognized organizations and societies such as the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the Advisory Committee on Immunizations Practices (ACIP), the American College of Obstetrics and Gynecology (ACOG) and the United States Preventive Services Task Force (USPSTF). The above organizations make recommendations based on reasonable medical evidence. We review the guidelines annually for content accuracy, current primary sources, new technological advances and recent medical research and make appropriate changes based on this review of the recommendations and/or preventive health mandates. We encourage physicians to utilize these guidelines to improve the health of our Covered Individuals.

The current guidelines are available on our website. To access the guidelines, go to **anthem.com**. Click on the **“Provider”** link in the top of the landing page (under the “Other Anthem Websites” section). Select your **state** and click **enter**. On the Provider Home page, under the **Health and Wellness** tab (on the blue toolbar) select or scroll to the **Practice Guidelines**, then select the link titled **“[Preventive Health Guidelines](#)”**.

With respect to the issue of coverage, each Covered Individual should review his/her Certificate of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. The Certificate of Coverage and/or Schedule of Benefits supersede the preventive health guidelines.

Cultural Diversity and Linguistic Services

[Cultural Diversity and Linguistic Services Overview](#)

Anthem recognizes that Providers and Facilities can encounter challenges when delivering health care services to a diverse population. Those challenges arise when Providers and Facilities need to cross a cultural divide to treat patients who may have different behaviors, attitudes and beliefs concerning health care. Differences in a patients’ ability to read may add an extra dimension of difficulty when Providers and Facilities try to encourage follow-through on treatment plans.

Anthem Cultural Diversity and Linguistic Services Toolkit, called "**Caring for Diverse Populations**," was developed to give Providers and Facilities specific tools for breaking through cultural and language barriers in an effort to better communicate with their patients. Sometimes the solution is as simple as finding the right interpreter for an office visit. Other times, a greater awareness of cultural sensitivities can open the door to the kind of interaction that makes treatment plans most effective: Has the individual been raised in a culture that frowns upon direct eye contact or receiving medical treatment from a member of the opposite sex? Is the individual self-conscious about his or her ability to read instructions?

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

We strongly encourage Providers and Facilities to access the complete toolkit: <http://bridginghealthcaregaps.com/>

The toolkit contents are organized into the following sections:

Improving Communications with a Diverse Patient Population Base

- Encounter tips for Providers and their clinical staff
- A memory aid to assist with patient interviews
- Help in identifying literacy problems
-

Tools and Training for Your Office in Caring for a Diverse Patient Base

- Interview guide for hiring clinical staff who have an awareness of cultural competency issues
- Availability of Medical Consumerism training for health educators to share with patients.

Resources to Communicate Across Language Barriers

- Tips for locating and working with interpreters
- Common signs and common sentences in many languages
- Language identification flashcards
- Language skill self-assessment tools

Primer on How Cultural Background Impacts Health Care Delivery

- Tips for talking with people across cultures about a variety of culturally sensitive topics

- Information about health care beliefs of different cultural backgrounds

Regulations and Standards for Cultural and Linguistic Services

- Identifies important legislation impacting cultural and linguistic services, including a summary of the “Culturally and Linguistically Appropriate Services” (CLAS) standards which serve as a guide on how to meet these requirements.

Resources for Cultural and Linguistic Services

- A bibliography of print and Internet resources for conducting an assessment of the cultural and linguistic needs of a practice’s patient population
- Staff and physician cultural and linguistic competency training resources
- Links to additional tools in multiple languages and/or written for limited English proficiency

The toolkit contains materials developed by and used with the permission of the Industry Collaboration Effort (ICE) Cultural and Linguistics Workgroup, a volunteer, multi-disciplinary team of providers, health plans, associations, state and federal agencies and accrediting bodies working collaboratively to improve health care regulatory compliance through public education. More information on the ICE Workgroup may be obtained on the ICE Workgroup website:

<http://www.iceforhealth.org/home/asp>.

Health and Wellness Programs

Providers can find more information about our member health and wellness programs on our public provider website under the Health & Wellness menu. Anthem.com and Comprehensive Medical Management are available to all Anthem members. Other programs offered may vary depending on the Covered Individual’s Health Benefit Plan.

Programs at a Glance:

Programs/Services	Description of Programs/Services
24/7 NurseLine	By calling a convenient toll-free number, members can get information and feedback about their health concerns from a registered nurse any time of the day or night.
Comprehensive Medical Management	<p>Utilization Management</p> <p>Includes pre-certification of medical procedures, imaging services and hospitalization to authorize care and to align medical services with the member’s benefits.</p> <p>Behavioral Health</p> <p>The program is designed to have case managers responsible for collaborating with healthcare providers and members to promote quality member outcomes, to optimize</p>

	<p>member benefits, and to promote effective use of resources. Please note that this is not a service that would replace standard behavioral health therapy or psychiatric evaluation given by a licensed provider within their community.</p> <p>Case Management</p> <p>Offers telephonic and video chat nursing support following a major hospitalization or procedure due to illness or injury. Cancer, NICU and transplant services included. Case Management helps members with maximizing medical benefits, arrange post-discharge care, and community health services.</p> <p>ComplexCare</p> <p>For those with multiple health issues or a condition that puts them at risk for frequent or high levels of medical care. Participants have access to ComplexCare nurses for individualized education as well as preventive care and self-management tips.</p>
Disease Management	<p>ConditionCare</p> <p>Provides members who have any one of the 5 core chronic diseases (diabetes, asthma, heart failure, coronary artery disease, and chronic obstructive pulmonary disease) with access to education and goal oriented health coaching from registered nurses. Members learn self management techniques that help to improve their quality of life, increase adherence to medical best practices, and avoid costly condition-related complications.</p> <p>ConditionCare End Stage Renal Disease (ESRD)</p> <p>Specializes in the care management of members who have ESRD. The ConditionCare ESRD program (administered by VillageHealth) educates members about their ESRD and assigns each member a primary nurse care manager to help them monitor their condition and guide them throughout the therapy process.</p>
Future Moms	<p>Provides individualized support to expectant moms to help them achieve healthier pregnancies and deliveries. Provides assistance from RNs trained in obstetrical care, the program provides education and support for high-risk and non-high-risk expectant mothers. The program focuses on helping to reduce the incidence of low-birth-weight infants and NICU admissions by keeping moms healthy and informed.</p>
Healthy Lifestyles	<p>Guided online experience to help improve member health. Healthy Lifestyles addresses how members' choices and behaviors can affect their physical, social and emotional well-being. The program provides members with a suite of integrated tools, including nutrition and exercise trackers, smoking cessation program, online coaching, tools and rewards. Participants can connect with others to share their experiences, get social support and tips on health topics.</p>
MyHealth Advantage	<p>Communicates gaps in care and health savings</p>

	opportunities to targeted members (via mailed MyHealth Notes) and gaps in care to their treating providers (via mail and online communications). MyHealth Advantage analyzes comprehensive health information and suggests ways members can be healthier and reduce out-of-pocket expenses.
Member Online Tools at Anthem.com	<p>Offers valuable health and wellness tools and resources to help members get the most out of their health care. It includes a health assessment, our online questionnaire that helps uncover possible health risks and ways to be healthier. Members can also keep track of their health with our confidential health record, get up-to-date health information, watch videos about health and wellness topics, and take advantage of health-related discounts.</p> <p>Find a Doctor Online tool that helps members determine if their current providers are in-network and helps them search for doctors, hospitals, pharmacies and more that are in their specific network.</p> <p>Estimate Your Cost Shares quality information and real price ranges for more than 150 common services at local area hospitals. Quality measures from state, federal, and private data include: procedure volume, facility-specific mortality and complication rates, average length of stay, patient safety – compliance with Leapfrog standards.</p>
Pharmacy	From our drug list to gaps-in-care and therapy management programs to home delivery and specialty pharmacy, our program offers more than prescription drug benefits. Our comprehensive generics program encourages members to transition from high-cost brand-name drugs to lower cost alternatives. And we offer members access to more than 65,000 pharmacies, including major chains and independents. Plus, we work directly with our medical partners to simplify the experience for employers and their employees.

Centers of Medical Excellence (“CME”)

Anthem currently offers access to Centers of Medical Excellence (CME) programs in solid organ and blood/marrow transplants, bariatric surgery, cardiac care, complex and rare cancer, spine surgery, and knee and hip replacement surgery. As much of the demand for CME programs has come from National Accounts, most of our programs are developed in partnership with the Blue Cross Blue and Shield Association (BCBSA) and other Blue plans to ensure adequate geographic coverage. The BCBSA refers to its designated CME hospitals as Blue Distinction Centers for Specialty Care™ (BDC). Anthem Covered Individuals have access through this program to Centers of Medical

Excellence, including Blue Distinction Centers for Specialty Care for transplant, bariatric surgery, cardiac care and complex and rare cancer, spine surgery and knee/hip replacements.

For transplants, Covered Individuals also have access to the Anthem Centers of Medical Excellence Transplant Network. The CME designation is awarded to qualified programs by a panel of national experts currently practicing in the fields of solid organ or marrow transplantation representing transplant centers across the country. Each Center must meet Anthem's CME participation requirements and is selected through a rigorous evaluation of clinical data that provides insight into the Facility's structures, processes, and outcomes of care. Current designations include the following transplants: autologous/allogeneic bone marrow/stem cell, heart, lung, combination heart/lung, liver, kidney, simultaneous kidney/pancreas and pancreas.

For both the BDC and Anthem CME programs, selection criteria are designed to evaluate overall quality, providing a comprehensive view of how the facility delivers specialty care. More information on our programs can be accessed online at anthem.com. Select Provider link in top center of page. Next, select Colorado/Nevada from the drop down list and enter. Hoover over the Health & Wellness tab, and select "[Centers of Medical Excellence](#)" from the drop down list.

Transplant

- The Blue Distinction Centers for Transplant (BDCT) program was launched in 2006. To date, approximately 100 Blue Distinction Centers for Transplant have been designated, representing more than 400 specific transplant programs across the country.
- The selection criteria for designation were developed in collaboration with the Center for International Blood and Marrow Transplant Research (CIBMTR[®]), the Scientific Registry of Transplant Recipients (SRTR) and the Foundation for the Accreditation of Cellular Therapy (FACT).
- The Anthem Centers of Medical Excellence (CME) Transplant Network is a wraparound network to the BDCT program and offers Anthem members access to an additional 60 transplant facilities. When BDCT and Anthem CME are combined, our members have access to 300 transplant specific programs for heart, lung, combined heart lung, liver, pancreas, combined kidney pancreas and bone marrow/stem cell transplant.

Cardiac Care

- Blue Distinction Centers for Cardiac Care were launched in January 2006.
- The American Heart Association estimates that 1.2 million Americans will experience a first or recurrent heart attack each year. Blue Distinction Centers for Cardiac Care provide a full range of cardiac care services, including inpatient cardiac care, cardiac rehabilitation, cardiac catheterization and cardiac surgery

(including coronary artery bypass graft surgery). To date, we have designated approximately 500 Blue Distinction Centers for Cardiac Care across the country.

- Blue Distinction Centers for Cardiac Care® have demonstrated their commitment to quality care, resulting in better overall outcomes for cardiac patients. Each facility meets stringent clinical criteria, developed in collaboration with expert physicians and medical organizations, including the American College of Cardiology (ACC) and the Society of Thoracic Surgeons (STS), and is subject to periodic reevaluation as criteria continue to evolve.

Bariatric Surgery

- Morbid obesity is widely recognized as a contributor to serious health risks. According to the Agency for Healthcare Research and Quality (AHRQ), between 1998 and 2004, the total number of bariatric weight-loss surgeries increased nine times, from 13,386 to 121,055. Blue Distinction® provides objective information to help patients make informed decisions when choosing a provider.
- Blue Distinction Centers for Bariatric Surgery® launched in 2008, have demonstrated their commitment to quality care, resulting in better overall outcomes for bariatric surgery patients. They offer comprehensive bariatric surgery care services, including inpatient care, post-operative care, outpatient follow-up care and patient education. To date, we have designated approximately 350 facilities nationwide that meet our evidence-based selection criteria. In determining the selection criteria for Blue Distinction, we collaborated with physician experts and medical organizations such as the American College of Surgeons (ACS), American Society for Metabolic and Bariatric Surgery (ASMBS) and the Surgical Review Corporation (SRC).

Complex and Rare Cancers

- Complex and rare cancers comprise approximately 15 percent of new cancer cases each year. Blue Distinction Centers for Complex and Rare Cancers® are the first in a line of anticipated Blue Distinction Centers® focused on cancer treatment.
- Blue Distinction Centers for Complex and Rare Cancers were launched in 2008 and offer access to 90 designated facilities for the treatment of 13 complex and rare cancers including esophageal cancer, pancreatic cancer, liver cancer, rectal cancer, gastric cancer, bone tumors, soft tissue sarcomas, brain tumors – primary, non-metastatic malignancies, bladder cancer, thyroid cancer – medullary or anaplastic, ocular melanoma and head and neck cancers.
- The Blue Distinction Centers for Complex and Rare Cancers program was developed in collaboration with the National Comprehensive Cancer Network (NCCN), with input from a panel of nationally recognized clinical experts and utilizing published evidence, where available.

Spine Surgery

- Blue Distinction Centers for Spine Surgery® launched in November 2009 and have demonstrated their commitment to quality care, resulting in better overall outcomes for spine surgery patients. Each Blue Distinction® facility meets objective clinical measures that are developed with input from expert physicians and medical organizations. To date, we have designated approximately 310 facilities across the country as Blue Distinction Centers for Spine Surgery that provide comprehensive inpatient spine surgery services, including discectomy, fusion and decompression procedures.

Knee and Hip Replacement

Blue Distinction Centers for Knee and Hip Replacement launched in November 2009 and provide comprehensive inpatient knee and hip replacement services, including total knee replacement and total hip replacement surgeries. To date, we have designated approximately 540 facilities nationwide as Blue Distinction Centers for Knee and Hip Replacement.

Member Grievance and Appeal Process

[Member Appeals](#)

Complaints and appeals

Anthem may have turned down your claim. We may have also denied your request to preauthorize or receive a service or a supply. If you disagree with Anthem's decision you can:

- 1) start a complaint
- 2) file an appeal or
- 3) file a grievance.

Complaints

If you want to start a complaint about Anthem's customer service or how we processed your claim, please call customer service. A trained staff member will try to clear up any confusion about the matter. They will also try to resolve your complaint. If you prefer, you can send a written complaint to this address:

Anthem Blue Cross and Blue Shield
Customer Service Department
P.O. Box 5747
Denver, CO 80217-5747

If your complaint isn't solved either by writing or calling, or if you don't want to file a complaint, you can file an appeal. We'll tell you how to do that next, in the Appeals section.

Appeals

It's best to file your appeal within 60 days of getting a denial. The absolute cut-off date for filing an appeal is 180 days from the day you were denied. You can appeal denials that were made either before you received service or after you received service. You can send an appeal in writing to:

Anthem Blue Cross and Blue Shield
Member Appeals Department
700 Broadway CAT 0430
Denver, CO 80273-0001

You don't have to start a complaint before you file an appeal. In your appeal, please state as plainly as possible why you think we shouldn't have denied your claim. Include any documents you didn't submit with the original claim or service/supply request. Also send any other document or documents that support your appeal.

To make sure you get a thorough, unbiased appeal, there are two levels of appeal. Also, if your claim was denied because of utilization review, you may request independent external review.

You don't have to file the appeal yourself. Someone else, like your doctor, can file any level of appeal for you. Just let us know in writing who will be filing the appeal for you.

Level 1 appeal

A Level 1 appeal will be reviewed by a person, who may be on our staff, but who wasn't involved in the denial. They may get information from co-workers or others who did make the decision. Where the decision is based on utilization review, the Level 1 appeal will involve a review by (or a discussion with) a person in the same medical specialty as the case being reviewed.

Unless you ask for or agree to a longer period, you'll get an answer to your appeal within 30 days from when we got your appeal request. But for appeals of services that were already performed, and which did not involve a denial based on utilization review, we'll answer the appeal in 60 days.

Level 2 appeal

If Anthem turned down your appeal at Level 1 you have the choice to continue to a Level 2 appeal. You have 60 days from our Level 1 decision to ask for a Level 2 appeal.

A Level 2 appeal gives you the chance to supply documents or information at an appeal hearing. You can do this in a couple of ways. You can come in person or you can use a

teleconference. You are encouraged to bring information, testimony, witnesses or other evidence that supports your appeal.

There will be at least three people who review your appeal. They could be Anthem employees. People who worked on your claim may present information, answer questions, or review the appeal. But a majority of the reviewers will not have worked on your claim before.

If your case involves utilization review, the people reviewing your appeal will be health care professionals. All reviewers:

- Will have appropriate expertise
- Will not have been previously involved in your case; and
- Will not be on our board of directors.
- Will not have a direct financial interest in the case or in the decision.

Anthem will give you a copy of the written decision. We'll also give a copy to any provider who may have represented you in the appeal. You'll get the copy within 60 days from the day we got your Level 2 request, unless you ask for or agree to a longer period.

Expedited appeals

You or your representative can ask for an expedited appeal if you had emergency services but haven't been discharged from the facility. Also, you can ask for an expedited appeal if the regular appeal schedule would do one of the following:

- Seriously jeopardize your life or health;
- Jeopardize your ability to regain maximum function;
- Create an immediate and substantial limitation on your ability to live independently, if you're disabled; or
- In the opinion of a physician with knowledge of your condition, would subject you to severe pain that can't be adequately managed without the service in question.

But expedited appeals are not available for denials made after the service has been provided.

Your request doesn't have to be in writing and can be made orally. We'll try to make the decision as soon as we can. But it won't take more than 72 hours. The reviewers won't be the people who denied your claim before. If you don't agree with the appeal decision, you can either continue to a Level 2 appeal, or request independent external review.

Independent external review appeals

For claims based on utilization review, you can request an independent external review appeal. For these appeals, your case is reviewed by an external review entity, selected by the Colorado Division of Insurance.

If you want to request an independent external review, you have to fill out a form. It's called the Request for Independent External Review of Carrier's Final Adverse Determination Form. (Your representative can fill it out for you too.) You can get the form from Anthem's customer service department. Once it's filled out, you need to send it to us.

You can ask for an independent external review within 4 months of your receipt of our Level 1 appeal decision, or within 60 days from receipt of the Level 2 appeal decision, or if we fail to complete the Level 1 appeal in the timeframes mentioned above.

Expedited independent external review appeals

You can request an expedited independent external review, but only if your case meets certain criteria. You will need a physician to certify to us that you have a medical condition where following the normal external review appeal process would seriously jeopardize your life or health, would jeopardize your ability to regain maximum function or, if you are disabled, would create an imminent and substantial limitation of your ability to live independently. If it meets these conditions, your request can be filed at the same time as your request for a Level 1 Appeal. Use the external review request form to request an expedited review. An expedited appeal may not be allowed for denials made after service was provided.

Grievances

You may send a written grievance to:

Anthem Blue Cross and Blue Shield
Quality Management Department
700 Broadway MC 0532
Denver, CO 80273

Anthem's Member Grievances Department will acknowledge that we've received your grievance. They'll also investigate it. We treat every grievance confidentially.

Division of Insurance inquiries

If you have a question about health care coverage in Colorado, please call the Division of Insurance at (303) 894-7490. Representatives will speak with you Monday through Friday, from 8:00 a.m. to 5:00 p.m. You can also write to:

The Division of Insurance
Attention ICARE Section
560 Broadway, Suite 850
Denver, Colorado 80202

The appeals process as defined above is for local claims and may or may not be the process by which National Account claims are handled. These processes

would be determined by the individual home plans based on their internal processes and may also be based on member or group contracts.

[How a Member can Obtain Language Assistance](#)

We are committed to communicating with our Members about their health plan, regardless of their language. We employ a Language Line interpretation service for use by all of our local member Customer Service Call Centers. The Member may simply call the Customer Service phone number on the back of their ID card and a representative will be able to assist them. Translation of written materials about their benefits can also be requested by contacting customer service. TTY/TDD services also are available by dialing 711. A special operator will contact Anthem to help with member needs.

Provider Complaint and Dispute Resolutions (Appeals) Process

[Provider Dispute Resolution \(Appeals\)](#)

Policy Statement

Provider-carrier dispute resolution requests must be submitted to Anthem's provider appeals department in writing or on the [Provider Dispute Resolution Form](#). Providers have one year from the date of the original EOB or RA to dispute a claims adjudication action. Provider-carrier dispute means an administrative, payment or other dispute between a participating provider and a carrier that does not involve a utilization review analysis and does not include routine provider inquiries that the carrier resolves in a timely fashion through existing informal processes (i.e., through customer service or submission of a [Claim Action Request Form](#).

The Provider dispute resolution process is available for administrative and payment issues only. For Local Plan claims, if your dispute involves utilization review (UR), it is not available for review as a provider appeal. However, Anthem will have an appropriate individual reconsider the UR decision in light of your concerns and notify you of the outcome. Also or instead, members may appeal UR decisions in accordance with the member appeals process. For BlueCard claims, provider disputes are filed directly to the local blue plan (Colorado). If the BlueCard provider dispute is regarding the member's benefits, and the provider is appealing on a member's behalf, appeals are coordinated with the member's benefit office for final determination.

Anthem shall make a determination of a provider dispute resolution request within forty-five (45) calendar days of receipt of all necessary information. When Anthem does not receive all necessary information to make a decision, Anthem shall request in writing within thirty (30) calendar days of receipt of the request the additional information needed. Anthem shall allow thirty (30) calendar days from the date of the request to receive the requested information. If the provider does not respond within the thirty (30)

calendar day timeframe, Anthem shall close the request without further review. Further consideration of the closed provider dispute resolution request must begin with a new request by the provider.

BlueCard Member appeals are filed directly to the home plans and time frames are determined by the member's home plan. BlueCard provider appeals are processed through the adjustment department and are not bound by time limits designated by state legislation. Benefit appeals are forwarded to the member's home plan and reviewed based on the time limits stipulated in the Member's contract and therefore are determined by the member's home plan.

Necessary Information

Necessary information consists of 1) each applicable date of service; 2) the subscriber or member name; 3) the patient name; 4) the subscriber or member ID number (including alpha prefix); 5) the provider name; 6) the provider tax ID number; 7) the dollar amount in dispute, if applicable; 8) the provider position statement explaining the nature of the dispute; and 9) supporting documentation when necessary, e.g., medical records, proof of timely filing.

Designating a Provider Representative and Face-to-face Opportunity

Anthem shall offer the provider the opportunity to designate a provider representative in the dispute resolution process. Anthem shall allow the provider or the provider's representative the opportunity to present the rationale for the dispute resolution request in person. In cases where the provider determines that a face-to-face meeting is not practical, Anthem shall offer the provider the opportunity to utilize alternative methods such as a teleconference or videoconference to present the rationale for the dispute resolution request. Anthem may require appropriate confidentiality agreements from representatives as a condition to participating in the dispute resolution process. The parties may mutually agree in writing to extend the timeframes beyond the forty-five (45) calendar days from receipt of all necessary information timeframe established by this regulation. National Accounts does not offer a face to face appeals process due to the involvement with multiple state plans.

Notification Requirements

For Local provider dispute resolution requests where all necessary information was provided, Anthem shall send written confirmation of receipt within thirty (30) calendar days of the dispute resolution request. The written confirmation must contain:

- a. A description of the carrier's dispute resolution procedures and timeframes;
- b. The procedures and timeframes for the provider or the provider's representative to present his rationale for the dispute resolution request; and
- c. The date by which the carrier must resolve the dispute resolution request.

When the appeal request is resolved in favor of the provider in accordance with this policy within thirty (30) days, the notice of favorable resolution will act as written confirmation.

In cases where the carrier does not receive all necessary information to make a decision, the carrier shall send, within thirty (30) days of receipt of the provider dispute resolution request, a written notice to the provider that must contain:

- a. A description of the additional necessary information required to process the request;
- b. The date that additional information must be provided by the provider; and
- c. A statement that failure to provide the requested information within thirty (30) calendar days from the carrier's request for additional information will result in the closure of the request with no further review.

In cases where the provider does not submit the additional necessary information required by the carrier and the carrier closes the request, the carrier shall notify the provider that the case is closed and that further consideration of the closed dispute resolution request must begin with a new request by the provider.

Anthem shall provide notification of the determination to the provider. In the event the determination is not in favor of the provider, the written notification shall include the principal reasons for the determination. The written notification shall contain:

- a. The names and titles of the parties evaluating the provider-carrier dispute resolution request, and where the decision was based on a review of medical documentation, the qualifying credentials of the parties evaluating the provider-carrier dispute resolution request;
- b. A statement of the reviewers' understanding of the reason for the provider's dispute;
- c. The reviewers' decision in clear terms and the rationale for the carrier's decision; and
- d. A reference to the evidence or documentation used as the basis for the decision.

Local providers have a single-step internal dispute resolution's process. Based on the type of issue being appealed, Anthem's provider advocates and medical directors, its medical review, medical policy and provider contracting departments, and/or other appropriate business areas may review appeal requests.

[Provider Dispute Resolution Form](#)

This form is available in electronic format for typing your information. Go to **anthem.com**, select the **Provider** link in top center of the page. Select **Colorado** from

drop down list and **enter**. From the **Answers@Anthem** tab, select the link titled **“Download Commonly Requested Forms”**, then **[“Provider Dispute Resolution Form”](#)**.

Please use the Provider Dispute Resolution Form, for all provider-carrier appeal requests. Send all requests to:

- **For Local Plan members and BlueCard members (all alpha prefixes other than R + 8 numerics):**

Anthem Blue Cross and Blue Shield
P.O. Box 5747
Denver, CO 80217-5747

- **For Federal Employee Program (FEP) members (alpha prefix R + 8 numerics):**

Federal Employee Program – Provider Appeals
P.O. Box 105557
Atlanta, GA 30348-5557

[Member Non-compliance Procedure](#)

If a member refuses treatment that an Anthem Provider or Facility has recommended, the provider may decide that the member’s refusal compromises the provider-patient relationship and obstructs the provision of proper medical care. Providers will try to render all necessary and appropriate professional services according to a member’s wishes when the services are consistent with the provider’s judgment. If a member refuses to follow the recommended treatment or procedure, the member is entitled to see another provider of the same specialty for a second opinion. The member may also pursue the appeal process. If the second provider’s opinion upholds the first provider’s opinion and the member still refuses to follow the recommended treatment, Anthem may then terminate the member’s coverage following thirty (30) calendar days’ notice to the member. If coverage is terminated, neither Anthem nor any provider associated with Anthem will have any further responsibility to provide care to the member.

Anthem may also cancel the coverage of any member who acts in a disruptive manner that prevents the orderly operation of any provider.

[Network Adequacy](#)

Anthem has established and monitors network adequacy standards to help ensure that our members have adequate, appropriate and timely access to PCPs (family and general practitioners, internists and pediatricians who have agreed to act as PCPs), high-volume specialists, hospitals and other health care providers. These adequacy standards include the number of providers, the geographic distribution of providers, and timely access for routine, emergency and urgent care conditions.

Colorado Access and Availability Standards

Accessibility – Plan’s members can obtain available services:

- PCP Regular/Routine Care
- PCP Urgent Care within same day or 1 day
- PCP After-Hours Care 24 X 7
- PCP Open Practice
- Member Complaints unavailable to get a timely appointment
- Member Telephone Service
 - Average Speed of Answer
 - Abandonment Rate
- Behavioral Health - After hours, 24/7 Emergency Access
- Behavioral Health-Emergency, non-LT within 6 hours
- Behavioral Health-Urgent within 48 hours
- Behavioral Health-Routine within 10 working days

Availability – The extent to which the Plan’s practitioners of the appropriate type and number are distributed geographically to meet the needs of its membership:

- PCP’s:
 - 20PCPs/10,000 members
- Specialists:
 - OB/GYN – 2.9 / 10,000
 - Ortho – 0.6 / 10,000
 - Surgery – 0.7 / 10,000
 - Cardiology – 0.5 / 10,000
 - Dermatology – 1 / 8,000
 - Gastroenterolgy – 1 / 8,000
 - Ophthamology – 1 / 8,000
 - Psychiatrists – 2 / 10,000
 - Non-MD BH – 8 / 10,000

Availability Geographic Distribution:

- PCP:
 - Urban – 2 in 20 miles
 - Rural – 2 in 60 miles
- OB-GYN:
 - Urban – 2 in 45 miles
 - Rural – 1 in 100 miles

- Specialist-Medical
 - Urban - 2 in 45 miles
 - Rural – 1 in 100 miles
- Specialist-Behavioral Health
 - Urban – 1 in 10 miles
 - Rural – 1 in 40 miles
- Hospitals-Medical
 - Urban – 1 in 30 miles
 - Rural – 1 in 60 miles
- Hospitals-Behavioral Health
 - Urban – 1 in 25 miles
 - Rural – 1 in 45 miles
- Pharmacy
 - Urban – 1 in 3 miles
 - Suburban – 1 in 5 miles
 - Rural – 1 in 15 miles

Urban or metro is defined as counties having a population of 50,000 or greater.

After Hours

After hours care is provided by physicians who may have a variety of ways of addressing members' needs. Members should call his/her PCP for instructions on how to receive medical care after the PCP's normal business hours, on weekends and holidays, or to receive non-Emergency Care and non-Urgent Care within the service area for a condition that is not life threatening but that requires prompt medical attention. In case of an Emergency, the Member should call 911 or go directly to the nearest Emergency room. If he/she is outside the service area, non-emergency Covered Service may be covered under the BlueCard Program.

Product Summary

[Product Summary](#)

Please see anthem.com for a full listing of Plans and Benefits. Go to **anthem.com**, select the **Provider** link in top center of the page. Select **Colorado** from drop down list and **enter**. From the [Plans & Benefits](#) tab, select from the following links for additional information:

- Group Health
- Individual Health

- Lumenos Consumer-Driven Health Plans
- Medicare Eligible
- Prescriptions
- Vision
- Anthem Behavioral Health
- Workers' Compensation
- Employee Assistance Program
- FEP
 - FEP link: Find out important information for all FEP members nationwide from the official FEP website at fepblue.org.
 - FEP Provider Information link: Find out specific provider information regarding the FEP.
- Dental
- Life

Products that Require Separate Agreements

- HMO
- HMOSelect
- Blue Priority
- Pathway (i.e. Pathway X Enhanced, Pathway Enhanced, or Pathway Network aka Highly Aligned Network)
- PPO
- Indemnity
- Medicare Advantage
- Workers' Compensation

Refer to your provider contracting representative or to Anthem's online provider directory to know if you are in-network for any of the networks listed above.

- If you don't know who your assigned contracting representative is, please reference the [Escalation Contact List](#). Or go to **anthem.com**, select the **Provider** link in top center of the page. Select **Colorado** from drop down list and **enter**. From the **Provider Home** tab, select the link titled **Contact Us (Escalation Contact List & Alpha Prefix Reference List)**.
- For a complete listing of Providers and Facilities, please check our online directory. Go to **anthem.com**, select the **Provider** link in top center of the page. Select **Colorado** from drop down list and **enter**. From the **Provider Home** tab, select the **enter** button from the blue box on the left side of page titled "[Find a Doctor](#)".

[BlueCard Website](#)

Please refer to the BlueCard section online for additional information. Go to **anthem.com**, select the **Provider** link in top center of the page. Select **Colorado** from drop down list and **enter**. From the **Communications** tab, select **Publications**, then [BlueCard Provider Manual](#). Select the link titled “**Section 3 – Products Included in the BlueCard Program**”.

[Federal Employee Health Benefits Program](#)

Please refer to the separate section titled Federal Employee Health Benefits Program for additional information.

[HMO Colorado Point-of-Service Rider](#)

HMO Colorado offers employer groups a point-of-service (“POS”) rider designed to complement BlueAdvantage HMO benefits. The POS rider is an “opt-out” product for members who want to receive covered health care services without guidance from a PCP in the HMO Colorado network.

In-network (HMO benefits): A member must select a PCP. If the member follows HMO Colorado guidelines and sees only the selected PCP or seeks services from in-network specialists, the member receives the member’s BlueAdvantage HMO benefits, less any in-network copayments. Emergency benefits are provided through HMO Colorado if the member follows HMO Colorado procedures.

Out-of-network (POS benefits): A member can choose to receive health care services from an out-of-network provider. Certain services under the POS provision will be covered at a lower level than services received from the selected PCP or in-network specialists. This means members may have to pay an annual deductible, as well as coinsurance, for these services. The out-of-network provider’s reimbursement for POS services is based on HMO Colorado’s maximum benefit allowance, according to the member’s Health Benefit Plan. Certain services require pre-certification.

The following services **are not covered benefits** under HMO Colorado’s POS provisions when rendered by an out-of-network provider, but they may be covered under the HMO provisions when rendered by an in-network PCP or an in-network specialist:

- Ambulance services (except emergency ambulance services)
- Infertility services
- Behavioral health care services, except biologically based mental health services, i.e., for parity diagnoses (see the Behavioral Health and Chemical Dependency Rehabilitation Services section of this Manual for a listing of parity diagnosis codes) or autism, posttraumatic stress disorder, dysthymia,

cyclothymia, social phobia, agoraphobia with panic disorder, general anxiety disorder, anorexia nervosa and bulimia nervosa

- Thirteen (13) Certain organ transplants

HMO Colorado Away from Home Care® Program

The Away from Home Care program is part of the BlueCard program and provides certain benefits to eligible members who are traveling outside their Blue Cross and/or Blue Shield HMO home plan's service area and staying in the service area of a participating Blue Cross and/or Blue Shield HMO host plan. The benefits provided under the Away from Home Care program are as follows:

- **Emergency care** for unexpected illness or injury that requires immediate medical care
- **Urgent care** for unexpected illness or injury that isn't life-threatening but that cannot reasonably be postponed until the member returns home. Urgent care includes follow-up to an initial urgent care visit.
- **Pre-certified follow-up care** for an injury or illness that originated in the HMO home plan service area that requires medical care while the member is traveling away from home. This care is pre-arranged by the member with the member's home plan before services are rendered. Follow-up care includes, but isn't limited to, services such as allergy shots, high-blood-pressure checks and cast removal.

Out-of-state Blue Cross and/or Blue Shield HMO plans have elected to use the BlueCard program to process urgent and follow-up care claims. Members of these plans will present their out-of-state member ID card at the time of service. These cards have a three-letter alpha prefix and a suitcase emblem that indicates their eligibility in the BlueCard program. Please collect any applicable copayments as listed on the member's ID card, and submit claims to the BlueCard address in the Telephone/Address Directory section of this Manual. These claims will be processed and priced according to the Provider or Facility's HMO Colorado contracted rates.

Local HMO Colorado member ID numbers will contain an XFF or XFY alpha prefix. Claims for HMO Colorado members are processed through the local HMO Colorado claims address listed in the Telephone/Address Directory section of this Manual and **not** through BlueCard.

The **Guest Membership** benefit of the Away from Home Care program provides courtesy membership for members who are temporarily residing outside their HMO home plan service area and who are enrolled in the HMO Colorado Guest Membership program. Members receive a courtesy enrollment from the HMO Colorado guest membership department and have access to a comprehensive range of benefits, including routine and preventive care services. Members must complete a Guest Services Application with their HMO home plan and then work with the HMO Colorado guest membership department to select a local PCP. The member pays any applicable

copayments and deductibles to the provider at the time of service, and HMO Colorado pays the provider.

BlueCard Member Eligibility

With the member's current ID card in hand, providers can verify membership and coverage by calling BlueCard eligibility at the phone number in the Telephone/Address Directory section. An operator will ask for the alpha prefix on the member's ID card and will connect the provider to the appropriate membership and coverage unit at the member's Blue Cross and Blue Shield plan.

If you can't locate an alpha prefix on the member's ID card, check for a phone number on the back of the ID card. If that's not available, call the provider customer service phone number in the [Alpha Prefix Reference List](#) in the Telephone and Address Directory section of the Manual.

HMOSelect™

Summary

HMOSelect is a suite of lower-cost HMO Health Benefit Plans with a select network of Centura facilities and other key health care providers in the seven-county Denver metro area, which includes Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas and Jefferson counties, the Colorado Springs area, which includes Elbert, El Paso and Teller counties, and northern Colorado. HMOSelect is offered by HMO Colorado, a subsidiary company of Anthem Blue Cross and Blue Shield.

HMOSelect includes coverage for preventive care, urgent and emergency care, hospital treatment and surgery, prescription drugs, and more. A rider for chiropractic care is also available. Member benefits, UM and authorization requirements, and customer service and claims processes are the same as for our HMO Colorado Health Benefit Plans.

HMOSelect Network

Hospitals: The HMOSelect network includes the following facilities:

- Centura Health's Denver metro facilities
 - Avista Adventist Hospital
 - Littleton Adventist Hospital
 - Parker Adventist Hospital
 - Penrose Adventist Hospital
 - Porter Adventist Hospital
 - St. Anthony Central Hospital
 - St. Anthony North Hospital
- The Children's Hospital

- Craig Rehabilitation Hospital
- Denver Health Medical Center
- Medical Center of the Rockies
- National Jewish Medical and Research Center
- Poudre Valley Hospital
- University of Colorado Hospital

Physicians: The HMO*Select* network includes more than two-thousand (2,000) physicians. All providers with admitting privileges to one of the participating hospitals were invited to participate in the network. This doesn't mean all providers who have admitting privileges to one of the participating hospitals have signed a HMO*Select* Amendment to their Agreement. Please see our provider directory at anthem.com for a listing of physicians participating in the HMO*Select* network.

Ancillary providers: As with the rest of the HMO*Select* network, the ancillary provider network is limited. Please see our provider directory at anthem.com for a listing of participating ancillary providers in the HMO*Select* network.

Product Details

- Members must select a PCP when enrolling.
- Members have open access to physician specialists in the HMO*Select* network without a referral from their PCP.
- Member benefits, UM and authorization requirements, and customer service and claims processes are the same as for our HMO Colorado Health Benefit Plans.

Identifying HMO*Select* Members

All member ID numbers will include the XFB or XFC alpha prefix.

Health Plan ID Cards

Please see the Membership Identification section for a sample HMO*Select* health plan ID card.

[Blue Priority](#)

Anthem's Blue Priority products are intended to better support the Patient Centered Primary Care concepts and put primary care physicians back at the center of the health care delivery system.

Patient Centered Medical Home pilots in Colorado and around the country have proven that this model works through; reduction in ER visits, reduced lengths of stay for

inpatient visits, improved generic prescription use, and improved satisfaction of primary care physicians/member.

Anthem's employer customers are requiring payers to deliver products that are more cost effective, but do not require them or their employees to compromise on quality.

The Blue Priority products:

- include both HMO and PPO plans and are available to Local Colorado large group and small group clients only. The Blue Priority products will be offered in metro Denver and Colorado Springs.
- require the selection of a primary care physician (PCP) for both the HMO and PPO options.
- require referral management for the HMO products that may improve the coordination of and quality of care as well as ensure the efficient use of services.
- allow the PCP to manage the whole patient throughout the continuum of care; preventive care through chronic care; and makes referrals as appropriate to other network physicians.

HMO – This network option:

- Includes a subset of PCPs and Specialists from Anthem's standard HMO network.
- provides coverage only when using the following selected PCP groups and selected specialists;
 - Primary Physician Partners
 - South Metro Primary Care Physicians
 - Children's Pediatric Partners
 - NewWest Physicians
 - Colorado Springs Health Partners
 - Mountain View Medical Group
- includes all facilities, ancillary providers, and behavioral health providers in the current HMO network;
- requires member selection of a PCP;
- requires referrals for most specialty care;
- no out-of-network benefits or access to most specialists without a referral
 - The exceptions are emergent and urgent care and specific types of specialty care as required by state law.



PPO – This three tier PPO option:


- requires member selection of a PCP;
- allows access to the broader Anthem PPO network without a referral;
- provides for the highest level of benefits when using the first tier of providers (Designated Providers); which are those PCPs and specialists in the HMO Blue Priority network;
- allows access to the second tier of providers (Participating Providers), which includes all other Anthem PPO contracted providers, at a reduced benefit.
- allows access to non-network providers at a significantly reduced benefit level.

Identifying Blue Priority Members:




Prefix	Account Name	Product Type
XFA	Colorado Blue Priority HMO (Small Group)	HMO
XFD	Colorado Blue Priority HMO (Large Group)	HMO
XFH	Colorado Blue Priority PPO (Small Group)	PPO
XFM	Colorado Blue Priority PPO (Large Group)	PPO


Health Plan ID Cards – HMO Sample copy:

 An Anthem Company	
JOHN DOE	
Identification Number ABC123A45678	MED PLAN:XYZ PCP: DR PCP 1-678-910-1112
Group No: GRPNBR	Primary Care \$000
Rx Bin: 610575	Specialist Care \$000
Coverage(s):	After Hrs/Urg Care \$000
DATACOVERAGES1	ER \$000
DATACOVERAGES2	Inpatient Hospital \$0000
HMO Colorado, Inc.	
Blue Priority 	

 An Anthem Company	anthem.com
Possession of this card does not guarantee payment of benefits.	Member Svcs 1-877-811-3106
Providers: File claims with patient's ID number directly to your local Blue Cross and/or Blue Shield Plan.	Provider Svcs 1-877-833-5742
	Pharmacist 1-800-662-0210
	Specialty Rx 1-800-870-6419
	24/7 NurseLine 1-800-337-4770
	Travel Coverage 1-800-810-2583
	Pre-Auth 1-800-832-7850
MEDICAL CLAIMS & INQ: PO BOX 5747 DENVER, CO 80217-5747	
<small>HMO Colorado Inc. is an independent licensee of the Blue Cross and Blue Shield Association.</small>	
<small>01/01/12</small>	

Health Plan ID Cards – PPO Sample copy:

	
JOHN DOE Identification Number ABC123A45678	
Group No: GRPNBR Rx Bin: 610575 Coverage(s): DATACOVERAGES1 DATACOVERAGES2	PCP: DR PCP 1-678-910-1112 Underwritten by Rocky Mtn. Hosp. and Med. Service, Inc. Primary Care \$50/\$100 Specialist Care \$100/\$50 After Hrs/Urg Care \$200 ER \$300 Inpatient Hospital \$1000 Ded. and Coins. May Apply CO-DOI
Blue Priority PPO  	

	
anthem.com Possession of this card does not guarantee payment of benefits. Providers: File claims with patient's ID number directly to your local Blue Cross and/or Blue Shield Plan.	
Member Svcs 1-877-811-3106 Provider Svcs 1-877-833-5742 Pharmacist 1-800-662-0210 Specialty Rx 1-800-870-6419 24/7 NurseLine 1-800-337-4770 Travel Coverage 1-800-810-2583 Pre-Auth 1-800-832-7850	MEDICAL CLAIMS & INQ: PO BOX 5747 DENVER, CO 80217-5747
<small>Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. an independent licensee of the Blue Cross and Blue Shield Association.</small>	
<small>01/01/12</small>	

Pathway

The Affordable Care Act (ACA) calls for the development of new health plans, which will be effective on January 1, 2014. These plans include Health Insurance Marketplaces (commonly referred to as Exchanges), as well as other health plans not purchased on the public exchange.

To support this initiative, Anthem developed a provider network to service these new health plans and better reflect the needs of our anticipated membership.

If a provider was selected to participate, please note that the HMO Colorado contract Amendment refers to the “Highly Aligned Network”, the network name which will be used on the member ID cards will include the name “Pathway”. It may be indicated as “Pathway X Enhanced”, “Pathway Enhanced” or “Pathway Network”. The network is the same, but the “X” determines that a product was purchased on the Exchange, and no “X” determines that the product was purchased off the Exchange. (For Off Exchange: “Pathway Enhanced” will be used for Small Group membership and “Pathway Network” will be used for Large Group members.) Either way, the network utilized for both on and off Exchange will be the same, but the naming may be slightly different.

HMO Colorado’s Pathway Network is a statewide network, but is aligned with specific hospitals in the Front Range. The Front Range Counties (Boulder, Denver Metro area, El Paso/Teller, Larimer and Pueblo) are aligned with the following hospital systems: Boulder Community Hospital, HCA (Medical Center of Aurora, North Suburban, PSL Denver, Rose Medical Center, Sky Ridge Medical Center and Swedish Medical Center), University Hospital, Memorial Hospital System, Pikes Peak Regional Medical Center, Poudre Valley, Medical Center of the Rockies, and Parkview Medical Center. All other counties include all hospitals and providers within our statewide HMO network. This Highly Aligned Network includes all behavioral health and ancillary providers (PT/OT/ST, home infusion, home health, DME, lab) in our standard HMO network.

The Pathway Network is open access; which means members will still need to choose a (Primary Care Physician (PCP), but do not need a referral from their PCP to see any of the Pathway Network providers.

Identifying Pathway Members:

Alpha Prefix	Health Benefits Plan Option	Product Type	Network Name (which will appear on Member ID cards)
VAB, XFFV	Individual (Exchange)	HMO	Pathway X Enhanced
VAA	Individual (OFF Exchange)	HMO	Pathway Enhanced
VAC	Small Group (Exchange)	HMO	Pathway X Enhanced
XFX	Small Group (OFF Exchange)	HMO	Pathway Enhanced
VAE	Large Group (OFF Exchange)	HMO	Pathway Network

[Health Insurance Exchange](#)

Anthem has developed a new “Pathway X Enhanced” network to support Health Insurance Exchange products that will be effective January 1, 2014. When purchased on the exchange, the network will be referred to “Pathway X Enhanced”. The network is the same as our “Pathway” network; please see the *Pathway* subsection for further details on the network which will be utilized on and off the exchange.

To learn more about Health Insurance Exchange information, please visit our dedicated webpage. Go to **anthem.com**, and select the **Provider** link at the top center of the page. Select **Colorado** from the drop down list, and **enter**. From the **Provider Home page**, under the **Communication and Updates section**, select the link titled “[Health Insurance Exchange information](#)”. New information will be posted to this web page as it becomes available.

Federal Employee Health Benefits Program

[FEHBP Requirements](#)

Providers and Facilities acknowledge and understand that Anthem participates in the Federal Employee Health Benefits Program (“FEHBP”) (aka Federal Employee Program “FEP”) – the health insurance Plan for federal employees. Providers and Facilities further understand and acknowledge that the FEHBP is a federal government program and the requirements of the program are subject to change at the sole direction and discretion of the United States Office of Personnel Management. Providers and Facilities agree to abide by the rules, regulations, and other requirements of the FEHBP as they exist and as they may be amended or changed from time to time, with or without prior notice. Providers and Facilities further agree that in the event of a conflict between the Provider or Facility agreement or this Provider Manual and the rules, regulations, or other requirements of the FEHBP, the terms of the rules, regulation, and other requirements of the FEHBP shall control.

When a conflict arises between federal and state laws and regulations, the federal laws and regulations supersede and preempt the state or local law (Public Law 105-266). In those instances, FEHBP is exempt from implementing the requirements of state legislation.

[Submission of Claims under the Federal Employee Health Benefits Program](#)

All claims under the FEHBP must be submitted to Plan for payment within three hundred and sixty five (365) calendar days from the date the Health Services are rendered. Providers and Facilities agree to provide to Plan, at no cost to Anthem or Covered Individual, all information necessary for Plan to determine its liability, including, without limitation, accurate and complete Claims for Covered Services, utilizing forms consistent with industry standards and approved by Plan or, if available, electronically through a medium approved by Plan. If Plan is the secondary payer, the three hundred and sixty five (365) calendar day period will not begin to run until Provider or Facility receives notification of primary payer's responsibility. Plan is not obligated to pay Claims received after this three hundred and sixty five (365) calendar day period. Except where the Covered Individual did not provide Plan identification, Provider or Facility shall not bill, collect or attempt to collect from Covered Individual for Claims Plan receives after the applicable period regardless of whether Plan pays such Claims.

[Erroneous or duplicate Claim payments under the Federal Employee Health Benefits Program](#)

For erroneous or duplicate Claim payments under the FEHBP, either party shall refund or adjust, as applicable, all such duplicate or erroneous Claim payments regardless of the cause. Such refund or adjustment may be made with five (5) years from the end of the calendar year in which the erroneous or duplicate Claim was submitted. In lieu of a refund, Plan may offset future Claim payments.

[Coordination of Benefits for FEHBP](#)

In certain circumstances when FEHBP is the secondary payer and there is no adverse effect on the Covered Individual, the FEHBP pays the local Plan allowable minus the Primary payment. The combined payments, from both the primary payer and FEHBP as secondary payer, might not equal the entire amount billed by the Provider or Facility for covered services.

[FEHBP Waiver requirements](#)

- Notice must identify the proposed services.
- Inform the Covered Individual that services may be deemed not medically necessary, experimental/investigational, or cosmetic by the Plan
- Provide an estimate of the cost for services.

- Covered Individual must agree in writing to be financially responsible in advance of receiving the services otherwise, the Provider or Facility will be responsible for the cost of services denied.

FEHBP Member Reconsiderations and Appeals

There are specific procedures for reviewing disputed Claims under the Federal Employee Health Benefits program. The process has two steps, starting with a review by the local Plan (reconsideration), which may lead to a review by the Office of Personnel Management (OPM).

The review procedures are designed to provide Covered Individuals with a way to resolve Claim problems as an alternative to legal actions.

The review procedures are intended to serve both contract holders and Covered Individuals. The local Plan and OPM do not accept requests for review from Providers or Facilities, except on behalf of, and with the written consent of, the contract holder or Covered Individual.

Providers and Facilities are required to demonstrate that the contract holder or Covered Individual has assigned all rights to the Provider or Facility for that particular Claim or Claims.

When a Claim or request for Health Services, drugs or supplies – including a request for precertification or prior approval – is denied, whether in full or partially, the local Plan that denied the Claim reviews the benefit determination on receiving a written request for review. This request must come from the Covered Individual, contract holder or their authorized representative. The request for review must be received within six months of the date of the Plan's final decision. If the request for review is on a specific Claim(s), the Covered Individual must be financially liable in order to be eligible for the disputed Claims process.

The local Plan must respond to the request in writing, affirming the benefits denial, paying the Claim, or requesting the additional information necessary to make a benefit determination, within 30 calendar days of receiving the request for review. If not previously requested, the Plan is required to obtain all necessary medical information, such as operative reports, medical records and nurses' notes, related to the Claim. If the additional information is not received within 60 calendar days, the Plan will make its decision based on the information available. Appropriate medical review will also be done at this time. If the Plan does not completely satisfy the Covered Individual's request, the Plan will advise the Covered Individual of his/her right to appeal to OPM.

Providers or Facilities may not submit appeals to the OPM. Only the Covered Individual or contract holder may do so, as outlined in the Federal Employee Program Service Benefit Plan brochure.

FEHBP Formal Provider and Facility Appeals

Providers and Facilities are entitled to pursue disputes of their **pre-service request** (this includes pre-certification or prior approval) or their **post-service claim** (represents a request for reimbursement of benefits for medical services that have already been performed), by following a formal dispute resolution process.

A formal Provider or Facility appeal is a written request from the rendering Provider or Facility to his/her local Plan, to have the Local Plan re-evaluate its contractual benefit determination of their post service Claim; to reconsider an adverse benefit determination of a pre-service request. The request must be from a Provider or Facility and must be written within 180 calendar days of the denial or benefit limitation. In most cases, this will be the date appearing on the Explanation of Benefits/Remittance sent by the Plan. For pre-service request denials, the date will be the date appearing on the Plan's notification letter.

The request for review may involve the Provider or Facility's disagreement with the local Plan's decision about any of the **clinical issues** listed below where the Providers or Facilities are not held harmless. Local Plans should note that this list is not all-inclusive.

1. not medically necessary (NMN);
2. experimental/investigational (E/I);
3. denial of benefits, in total or in part, based on clinical rationale (NMN or E/I);
4. precertification of hospital admissions; and,
5. prior approval (for a service requiring prior approval under FEP).

Not all benefit decisions made by local Plans are subject to the formal Provider and Facility appeal process. The formal Provider and Facility appeal process does not apply to any non-clinical case.

When a Claim or request for services, drugs or supplies – including a request for precertification or prior approval – is denied, whether in full or partially, the local Plan that denied the Claim reviews the benefit determination on receiving a written request for review. This request must come from the rendering/requesting Provider or Facility. The request for review must be received within six months of the date of the local Plan's final decision. If the request for review is on a specific Claim(s), the Provider or Facility must be financially liable in order to be eligible for the formal Provider and Facility appeal process.

The local Plans must respond to the request in writing, affirming the benefits denial, paying the Claim, or requesting the additional information necessary to make a benefit determination, within 30 calendar days of receiving the request for review. If not previously requested, the local Plan is required to obtain all necessary medical information, such as operative reports, medical records and nurses' notes, related to the Claim. If the additional information is not received within 60 calendar days, the local

Plan will make its decision based on the information available. Appropriate medical review will also be done at this time. Even If the local Plan does not completely satisfy the Provider or Facility's request, the formal Provider and Facility appeal process is complete; no additional appeal rights are available.

Medicare Advantage

[Medicare Advantage Provider Website](#)

Please refer to the Medicare Eligible website online for additional information at www.anthem.com/medicareprovider.

Medicare Advantage Provider Manuals are available on the Medicare Eligible website referenced above.

- [Medicare Advantage HMO and PPO Provider Guidebook](#)
-

Medicare Crossover

[Duplicate Claims Handling for Medicare Crossover](#)

Since January 1, 2006, all Blue Plans have been required to process Medicare crossover Claims for services covered under Medigap and Medicare Supplemental products through Centers for Medicare & Medicaid Services (CMS). This has resulted in automatic submission of Medicare Claims to the Blue secondary payer to eliminate the need for Providers or Facilities or his/her/its billing service to submit an additional Claim to the secondary carrier. Additionally, this has also allowed Medicare crossover Claims to be processed in the same manner nationwide.

Effective October 13, 2013 when a Medicare Claim has crossed over, Providers and Facilities are to wait 30 calendar days from the Medicare remittance date before submitting the Claim to the local Plan if the charges have still not been considered by the Covered Individual's Blue Plan.

If Provider or Facility provides Covered Individuals' Health Plan ID numbers (including alpha prefix) when submitting Claims to the Medicare intermediary, they will be crossed over to the Blue Plan only after they have been processed by the Medicare intermediary. This process will take a minimum of 14 days to occur. This means that the Medicare intermediary will be releasing the Claim to the Blue Plan for processing about the same time Provider or Facility receives the Medicare remittance advice. As a result, upon receipt of the remittance advice from Medicare, it may take up to 30 additional

calendar days for Provider or Facility to receive payment or instructions from the Blue Plan.

Providers and Facilities should continue to submit services that are covered by Medicare directly to Medicare. Even if Medicare may exhaust or has exhausted, continue to submit Claims to Medicare to allow for the crossover process to occur and for the Covered Individual's benefit policy to be applied.

Medicare primary Claims, including those with Medicare exhaust services, that have crossed over and are received within 30 calendar days of the Medicare remittance date or with no Medicare remittance date, will be rejected by the local Plan.

Effective October 13, 2013, we will reject Medicare primary provider submitted Claims with the following conditions:

- Medicare remittance advice remark codes MA18 or N89 that Medicare crossover has occurred
 - MA18 Alert: The Claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
 - N89 Alert: Payment information for this Claim has been forwarded to more than one other payer, but format limitations permit only one of the secondary payers to be identified in this remittance advice.
- Received by Provider or Facility's local Plan within 30 calendar days of Medicare remittance date
- Received by Provider or Facility's local Plan with no Medicare remittance date
- Received with GY modifier on some lines but not all
 - A GY modifier is used by Providers and outpatient Facilities when billing to indicate that an item or service is statutorily excluded and is not covered by Medicare. Examples of statutorily excluded services include hearing aids and home infusion therapy.

When these types of Claims are rejected, Anthem will also remind the Provider or Facility to allow 30 days for the crossover process to occur or instruct the Provider or Facility to submit the Claim with only GY modifier service lines indicating the Claim only contains statutorily excluded services.

[Medicare statutorily excluded services – just file once to your local Plan](#)

There are certain types of services that Medicare never or seldom covers, but a secondary payer such as Anthem may cover all or a portion of those services. These are statutorily excluded services. For services that Medicare does not allow, such as home infusion, Providers and outpatient Facilities need only file statutorily excluded services directly to their local Plan using the GY modifier and will no longer have to

submit to Medicare for consideration. These services must be billed with only statutorily excluded services on the Claim and will not be accepted with some lines containing the GY modifier and some lines without.

For Claims submitted directly to Medicare with a crossover arrangement where Medicare makes no allowance, Providers and Facilities can expect the Covered Individual's benefit plan to reject the Claim advising the Provider or Facility to submit to their local Plan when the services rendered are considered eligible for benefit. These Claims should be resubmitted as a fresh Claim to a Provider or Facility's local Plan with the Explanation of Medicare Benefits (EOMB) to take advantage of Provider or Facility contracts. Since the services are not statutorily excluded as defined by CMS, no GY modifier is required. However, the submission of the Medicare EOMB is required. This will help ensure the Claims process consistent with the Provider's or Facility's contractual agreement.

Effective October 13, 2013:

- Providers or outpatient Facilities who render statutorily excluded services should indicate these services by using GY modifier at the service line level of the Claim.
- Providers or Facilities will be required to submit only statutorily excluded service lines on a Claim (cannot combine with other services like Medicare exhaust services or other Medicare covered services)
- The Provider or outpatient Facility's local Plan will not require Medicare EOMB for statutorily excluded services submitted with a GY Modifier.

If Providers or outpatient Facilities submit combined line Claims (some lines with GY, some without) to their local Plan, the Provider or outpatient Facility's local Plan will deny the Claims, instructing the Provider or outpatient Facility to split the Claim and resubmit.

Original Medicare – The GY modifier *should* be used when service is being rendered to a Medicare primary Covered Individual for statutorily excluded service and the Covered Individual has Blue secondary coverage, such as an Anthem Medicare Supplement plan. The value in the SBR01 field should not be "P" to denote primary.

Medicare Advantage – Please ensure SBR01 denotes "P" for primary payer within the 837 electronic Claim file. This helps ensure accurate processing on Claims submitted with a GY modifier.

The GY modifier *should not* be used when submitting:

- Commercial Claims
- Federal Employee Program Claims
- Inpatient institutional Claims. Please use the appropriate condition code to denote statutorily excluded services.

These processes align Blue Cross and/or Blue Shield plans with industry standards and will result in less administrative work, accurate payments and fewer rejected Claims. Because the Claim will process with a consistent application of pricing, our Covered Individuals will also see a decrease in health care costs as the new crossover process eliminates or reduces balance billing to the Covered Individual.

Providers and Facilities can call the E-Solutions Help Desk at 800-470-9630, or go to the www.anthem.com/EDI webpage to request assistance with submitting electronic Claims to us. If you have any questions about where to file your Claim, please contact the Provider Customer Service phone number on the back of the Covered Individual's ID card.

Audit

Anthem Audit Policy

This Anthem Audit Policy applies to Providers and Facilities. If there is conflict between this Policy and the terms of the applicable Facility or Provider Agreement, the terms of the Agreement will prevail. If there is a conflict in provisions between this Policy and applicable state law that is not addressed in the Facility or Provider Agreement the state law will apply. All capitalized terms used in this Policy shall have the meaning as set forth in the Facility or Provider Agreement between Anthem and Provider or Facility.

Coverage is subject to the terms, conditions, and limitations of a Covered Individual's Health Benefit Plan and in accordance with this Policy.

Definition:

The following definitions shall apply to this Audit section only:

- Agreement means the written contract between Anthem and Provider or Facility that describes the duties and obligations of Anthem and the Provider or Facility, and which contains the terms and conditions upon which Anthem will reimburse Provider or Facility for Health Services rendered by Provider or Facility to Anthem Covered Individual(s).
- Appeal means Anthem's review of the disputed portions of the Audit Report, conducted at the written request of a Provider or Facility and pursuant to this Policy.
- Appeal Response means Anthem's written response to the Appeal after reviewing all Supporting Documentation provided by Provider or Facility.
- Audit means a qualitative or quantitative review of Health Services or documents relating to such Health Services rendered, by Provider or Facility, and conducted

for the purpose of determining whether such Health Services have been appropriately reimbursed under the terms of the Agreement.

- **Audit Report and Notice of Overpayment ("Audit Report")** means a document that constitutes notice to the Provider or Facility that Anthem or its designee believes an overpayment has been made by Anthem identified as the result of an Audit. The Audit Report shall contain administrative data relating to the Audit, including the amount of overpayment and findings of the Audit that constitute the basis for Anthem's or its designee's belief that the overpayment exists. Unless otherwise stated in the Agreement between the Provider or Facility and Anthem, Audit Reports shall be sent to Provider or Facility in accordance with the Notice section of the Agreement.
- **Business Associate** means a third party designated by Anthem to perform an Audit or any related Audit function on behalf of Anthem pursuant to a written agreement with Anthem.
- **Provider or Facility** means an entity with which Anthem has a written Agreement.
- **Provider Manual** means the proprietary Anthem document available to Provider and Facility, which outlines certain Anthem Policies.
- **Recoupment** means the recovery of an amount paid to Provider or Facility which Anthem has determined constitutes an overpayment not supported by an Agreement between the Provider or Facility and Anthem. A Recoupment is generally performed against a separate payment Anthem makes to the Provider or Facility which is unrelated to the services which were the subject of the overpayment, unless an Agreement expressly states otherwise or is prohibited by law. Recoupments shall be conducted in accordance with applicable laws and regulations.
- **Supporting Documentation** means the written material contained in a Covered Individual's medical records or other Provider or Facility documentation that supports the Provider's or Facility's claim or position that no overpayment has been made by Anthem.

Procedure:

1. **Review of Documents.** Anthem or its designee will request in writing or verbally, final and complete itemized bills and/or complete medical records for all Claims under review. The Provider or Facility will supply the requested documentation in the format requested by Anthem within thirty (30) calendar days of Anthem's request.
2. **Scheduling of Audit.** After review of the documents submitted, if Anthem or its designee determines an Audit is required, Anthem will call the Provider or Facility

to request a mutually satisfactory time for Anthem to conduct an Audit; however, the Audit must occur within forty-five (45) calendar days of the request.

3. Rescheduling of Audit. Should Provider or Facility desire to reschedule an Audit, Provider or Facility must submit its request with a suggested new date, to Anthem or its designee in writing at least seven (7) calendar days in advance of the day of the Audit. Provider's or Facility's new date for the Audit must occur within thirty (30) calendar days of the date of the original Audit. Provider or Facility may be responsible for cancellation fees incurred by Anthem or its designee due to Provider's or Facility's rescheduling.
4. Under-billed and Late-billed Claims. During the scheduling of the Audit, Provider or Facility may identify Claims for which Provider or Facility under-billed or failed to bill for review by Anthem during the Audit. Under-billed or late-billed Claims not identified by Provider or Facility before the Audit commences will not be evaluated in the Audit. These Claims may, however, be submitted (or resubmitted for under-billed Claims) to Anthem for adjudication.
5. Scheduling Conflicts. Should the Provider or Facility fail to work with Anthem in scheduling or rescheduling the Audit, Anthem or its designee retains the right to conduct the Audit with a seventy-two (72) hour advance written notice, which Anthem or its designee may invoke at any time. While Anthem or its designee prefers to work with the Provider or Facility in finding a mutually convenient time, there may be instances when Anthem or its designee must respond quickly to requests by regulators or its clients. In those circumstances, Anthem or its designee will send a notice to the Provider or Facility to schedule an Audit within the seventy-two (72) hour timeframe.
6. On-Site and Desk Audits. Anthem or its designee may conduct Audits from its offices or on-site at the Provider's or Facility's location. If Anthem or its designee conducts an Audit at a Provider's or Facility's location, Provider or Facility will make available suitable work space for Anthem's on-site Audit activities. During the Audit, Anthem or its designee will have complete access to the applicable health records including ancillary department records and/or invoice detail without producing a signed Covered Individual authorization. When conducting credit balance reviews, Provider or Facility will give Anthem or its designee a complete list of credit balances for primary, secondary and tertiary coverage, when applicable. In addition, Anthem or its designee will have access to Provider's or Facility's patient accounting system to review payment history, notes, Explanation of Benefits and insurance information to determine validity of credit balances. If the Provider or Facility refuses to allow Anthem access to the items requested to complete the Audit, Anthem or its designee may opt to complete the Audit based on the information available. All Audits (to include medical chart audits and diagnosis related group reviews) shall be conducted free of charge despite any Provider or Facility policy to the contrary.

7. Completion of Audit. Upon completion of the Audit, Anthem or its designee will generate and give to Provider or Facility a final Audit Report. This Audit Report may be provided on the day the Audit is completed or it may be generated after further research is performed. If further research is needed, the final Audit Report will be generated at any time after the completion of the Audit, but generally within ninety (90) days. Occasionally, the final audit report will be generated at the conclusion of the exit interview which is performed on the last day of the Audit. During the exit interview, Anthem or its designee will discuss with Provider or Facility, its Audit findings found in the final Audit Report. This Audit Report may list items such as charges unsupported by adequate documentation, under-billed items, late billed items and charges requiring additional supporting documentation. If the Provider or Facility agrees with the Audit findings, and has no further information to provide to Anthem or its designee, then Provider or Facility may sign the final Audit Report acknowledging agreement with the findings. At that point, Provider or Facility has thirty (30) calendar days to reimburse Anthem the amount indicated in the final Audit Report. Should the Provider or Facility disagree with the final Audit Report generated during the exit interview, then Provider or Facility may either supply the requested documentation, or Appeal the Audit findings.
8. Provider or Facility Appeal's. See Audit Appeal Policy.
9. No Appeal. If the Provider or Facility does not formally Appeal the findings in the final Audit Report **and** submit supporting documentation within the thirty (30) calendar day timeframe, the initial determination will stand and Anthem or its designee will process adjustments to recover amount identified in the final Audit Report.

Documents Reviewed During an Audit:

The following is a description of the documents that may be reviewed by the Anthem or its designee along with a short explanation of the importance of each of the documents in the Audit process. It is important to note that Providers and Facilities must comply with applicable state and federal record keeping requirements.

- A. Confirm that Health Services were delivered by the Provider or Facility in compliance with the physician's plan of treatment.

Auditors will verify that Provider's or Facility's plan of treatment reflected the Health Services delivered by the Provider or Facility. The services are generally documented in the Covered Individual's health or medical records. In situations where such documentation is not found in the Covered Individual's medical record, the Provider or Facility may present other documents substantiating the treatment or Health Service, such as established institutional policies, professional licensure standards that reference standards of care, or business practices justifying the Health Service or supply. The Provider or Facility must

review, approve and document all such policies and procedures as required by The Joint Commission (“TJC”) or other applicable accreditation bodies. Policies shall be made available for review by the auditor.

- B. Confirm that charges were accurately reported on the claim in compliance with Anthem’s Policies as well as general industry standard guidelines and regulations.

The auditor will verify that the billing is free of keystroke errors. Auditors may also review the Covered Individual’s health record documents. The health record records the clinical data on diagnoses, treatments, and outcomes. A health record generally records pertinent information related to care and in some cases, the health record may lack the documented support for each charge on the Covered Individual’s claim. Other appropriate documentation for Health Services provided to the Covered Individual may exist within the Provider’s or Facility’s ancillary departments in the form of department treatment logs, daily charge records, individual service/order tickets, and other documents. Anthem or its designee may have to review a number of documents in addition to the health record to determine if documentation exists to support the Charges on the Covered Individual’s claim. The Provider or Facility should make these records available for review and must ensure that Policies exist to specify appropriate documentation for health records and ancillary department records and/or logs.

[Audit Appeal Policy](#)

Purpose:

To establish a timeline for issuing Audits and responding to Provider or Facility Appeals of such Audits.

Procedure:

1. Unless otherwise expressly set forth in an Agreement, Provider or Facility shall have the right to Appeal the Audit Report. An Appeal of the Audit Report must be in writing and received by Anthem or its designee within thirty (30) calendar days of the date of the Audit Report unless State Statute expressly indicates otherwise. The request for Appeal must specifically detail the findings from the Audit Report that Provider or Facility disputes, as well as the basis for the Provider’s or Facility’s belief that such finding(s) are not accurate. All findings disputed by the Provider or Facility in the Appeal must be accompanied by relevant Supporting Documentation. Retraction will begin at the expiration of the thirty (30) calendar days unless expressly prohibited by contractual obligations or State Statute.

2. A Provider's or Facility's written request for an extension to submit an Appeal complete with Supporting Documentation or payment will be reviewed by Anthem or its designee on a case-by-case basis. If the Provider or Facility chooses to request an Appeal extension, the request should be submitted in writing within thirty (30) calendar days of receipt of the Audit Report. One Appeal extension may be granted during the Appeal process at Anthem's or its designee's sole discretion, for up to thirty (30) calendar days from the date the Appeal would otherwise have been due. Any extension of the Appeal timeframes contained in this Policy shall be expressly conditioned upon the Provider's or Facility's agreement to waive the requirements of any applicable state prompt pay statute and/or provision in an Agreement which limits the timeframe by which a Recoupment must be completed. It is recognized that governmental regulators are not obligated to the waiver.
3. Upon receipt of a timely Appeal, complete with Supporting Documentation as required under this Policy, Anthem or its designee shall issue an Appeal Response to the Provider or Facility. Anthem's or its designee's response shall address each matter contained in the Provider's or Facility's Appeal. If appropriate, Anthem's or its designee's Appeal Response will indicate what adjustments, if any, shall be made to the overpayment amounts outlined in the Audit Report. Anthem's or its designee's response shall be sent via certified mail to the Provider or Facility within thirty (30) calendar days of the date Anthem or its designee received the Provider's or Facility's Appeal and Supporting Documentation. Revisions to the Audit data will be included in this mailing if applicable.
4. The Provider or Facility shall have fifteen (15) calendar days from the date of Anthem's or its designee's Appeal Response to respond with additional documentation or, if appropriate in the State, a remittance check to Anthem or its designee. If no Provider or Facility response or remittance check (if applicable) is received within the fifteen (15) calendar day timeframe, Anthem or its designee shall begin recoupment the amount contained in Anthem's or its designee's response, and a confirming recoupment notification will be sent to the Provider or Facility.
5. Upon receipt of a timely Provider or Facility response, complete with Supporting Documentation as required under this Policy, Anthem or its designee shall formulate a final Appeal Response. Anthem's or its designee's final Appeal Response shall address each matter contained in the Provider's or Facility's response. If appropriate, Anthem's or its designee's final Appeal Response will indicate what adjustments, if any, shall be made to the overpayment amounts outlined in the Audit Report or final Appeal Response. Anthem's or its designee's final Appeal Response shall be sent via certified mail to the Provider or Facility within fifteen (15) calendar days of the date Anthem or its designee received the Provider or Facility response and Supporting Documentation. Revisions to the Audit Report will be included in this mailing if applicable.

6. If applicable in the state, the Provider or Facility shall have fifteen (15) calendar days from the date of Anthem's or its designee's final Appeal Response to send a remittance check to Anthem or its designee. If no remittance check is received within the fifteen (15) calendar day timeframe, Anthem or its designee shall recoup the amount contained in Anthem's or its designee's final Appeal Response, and a confirming Recoupment notification will be sent to the Provider or Facility.
7. If Provider or Facility still disagrees with Anthem's or its designee's position after receipt of the final Appeal Response, Provider or Facility may invoke the dispute resolution mechanisms under the Agreement.

Fraud, Abuse and Waste Detection

Anthem recognizes the importance of preventing, detecting, and investigating fraud, abuse and waste, and is committed to protecting and preserving the integrity and availability of health care resources for our members, clients, and business partners. Anthem accordingly maintains a comprehensive program to combat fraud, abuse, and waste in the healthcare industry.

Anthem's Special Investigations Unit (SIU) leads this program, particularly as related to fraud, abuse and waste. SIU's mission is to combat fraud, abuse and waste against our various commercial plans, and to seek to ensure the integrity of publicly-funded programs, including Medicare and Medicaid plans.

Pre-Payment Review

One method Anthem utilizes to detect fraud, abuse and waste is through pre-payment review. Through a variety of means, certain Providers or Facilities of health care or certain Claims submitted by Providers or Facilities may come to Anthem's attention for some reason or behavior that might be identified as unusual, or which indicates the Provider or Facility is an outlier with respect to his/her/its peers. One such method is through computer algorithms that are designed to identify a Provider or Facility whose billing practices or other factors indicate conduct that is unusual or outside the norm of their peers.

Once such an unusual Claim is identified or a Provider or Facility is identified as an outlier, further investigation is conducted by SIU to determine the reason(s) for the outlier status or any approximate explanation for an unusual Claim. If the investigation results in a determination that the Provider's or Facility's actions may involve fraud, abuse or waste, the Provider or Facility is notified and given an opportunity to respond.

If, despite the Provider's or Facility's response, we continue to believe the Provider's or Facility's actions involve fraud, abuse or waste, or some other inappropriate activity, the Provider or Facility is notified he/she/it is being placed on pre-payment review. This

means that the Provider or Facility will be required to submit medical records with each Claim submitted so that we will be able to review them compared to the services being billed. Failure to submit medical records to Anthem in accordance with this provision may result in a denial of a Claim under review. The Provider or Facility will be given the opportunity to appeal his/her/its pre-payment review status in accordance with the procedures set forth in the applicable Provider or Facility contract

The Provider or Facility will remain subject to the pre-payment review process until we are satisfied that any inappropriate activity has been corrected. If the inappropriate activity is not corrected, the Provider or Facility could face corrective measures, up to and including termination from our Provider or Facility network.

Finally, Providers and Facilities are prohibited from billing Covered Individuals for services we have determined are not payable as a result of the pre-payment review process, whether due to fraud, abuse, waste or any other billing issue or for failure to submit medical records as set forth above. Providers or Facilities whose Claims are determined to be not payable may make appropriate corrections and resubmit such Claims in accordance with the terms of the applicable provider agreement and state law. Providers or Facilities also may appeal such determination in accordance with applicable grievance procedures.

Laboratory Services

Laboratory Procedures

Anthem is contracted with Laboratory Corporation of America[®] ("LabCorp"). All lab work, including Pap tests and routine outpatient pathology, must be sent to LabCorp, with the exception of the procedures listed below that can be performed in the Provider's office or sent to LabCorp:

Note: This relationship with LabCorp is specific to national reference lab services and **does not affect** network hospital-based lab service providers, contracted pathologists, or independent laboratories.

Lab Work that can be provided in the Provider's Office			
HCPCS	Description	HCPCS	Description
80048	Metabolic panel total	85025	Complete CBC w/auto diff WBC
81000	Urinalysis, nonauto w/scope	85610	Prothrombin time
81001	Urinalysis, auto w/scope	86308	Heterophile antibodies (momo spot)
81002	Urinalysis nonauto w/o	86403	Particle agglutination test

Lab Work that can be provided in the Provider's Office			
HCPCS	Description	HCPCS	Description
	scope		(Rapid Strep)
81003	Urinalysis, auto, w/o scope	86580	TB intradermal test
81005	Urinalysis	87081	Culture screen only (Rapid Strep)
81007	Urine screen for bacteria	87205	Smear, gram stain
81015	Microscopic exam of urine	87210	Smear, wet mount, saline/ink
81025	Urine pregnancy test	87220	Tissue exam for fungi
82120	Amines, vaginal fluid, qualitative	87430	Strep a ag, eia (Rapid Strep)
82270	Occult blood, feces	87802	Infectious agent antigen detection by immunoassay with direct optical observation; Streptococcus, group B
82271	Occult blood, other sources	87804	Influenza assay w/optic
82803	Gases, blood, any combination of pH, pCO ₂ , pO ₂ , CO ₂ , HC0 ₃ (including calculated O ₂ saturation). This procedure approved for Pulmonologists ONLY.	87807	Rsv assay w/optic
82947	Glucose; quantitative (except reagent strip)	87880	Strep a assay w/optic
82948	Glucose; blood reagent strip	89300	Semen analysis w/huhner
82962	Glucose; blood by glucose monitoring device(s) cleared by the FDA specifically for home use.	89310	Semen analysis w/count
85002	Bleeding time	89320	Semen analysis, complete
85007	Blood count; blood smear, microscopic examination with manual differential WBC count	89321	Semen analysis & motility
85013	Spun microhematocrit	89330	Sperm evaluation; cervical mucus penetration test,

Lab Work that can be provided in the Provider's Office			
HCPCS	Description	HCPCS	Description
			with or without spinnbarkeit test
85014	Hematocrit	G0027	Semen analysis
85018	Hemoglobin		

Lab procedure codes for procedures that can be performed at the physician's office can be billed as fee-for-service. Codes on this list are not a guarantee of payment. Coverage may be restricted by member benefits.

Venipuncture and blood collection services:

- Effective January 1, 2010, codes 36415 and S9529 venipuncture, and/or 36416, collection of capillary blood specimen (e.g. finger, heel, or ear stick) are allowed in addition to the lab and/or the E/M code. (Only one of these codes should be reported per visit).
- Anthem follows 2014 CPT parenthetical coding guidelines which state that CPT codes 36591 – Collection of blood specimen from a completely implantable venous access device and 36592 – Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified, should not be reported "...in conjunction with other services except a laboratory service¹". Therefore, these codes are only eligible for separate reimbursement when billed with a laboratory service.
- Please refer to Reimbursement Policy: *Laboratory and Venipuncture Services* for implementation dates for ClaimsXten editing for these services.

¹current procedural terminology *cpt*® 2013 Professional Edition, pg. 215

Code 99000, handling or conveyance of a specimen, is on Reimbursement Policy: *Bundled Services and Supplies* and is considered part of the overall medical management of the patient and is not reimbursed separately.

Reviewing results of laboratory tests, phoning results to patients, filing such results, etc., are included in Anthem's allowance for the E/M code, even if the E/M code is not on the same day.

A charge related to drawing of blood performed by an OB/GYN is payable as a separate service and isn't included in the total obstetrical allowance if the blood is sent to the lab.

An appropriate diagnosis to justify the procedure must accompany all lab procedures.

Specimen collections: For specimen requirements for various lab tests, collection procedures, specimen preparations and submission protocols, please call LabCorp at 303-792-2600 or toll free at 800-795-3699. Instructions for certain labile specimens are as follows:

- Routine pediatric specimen collections can be performed at the drawing stations of the independent laboratories contracted with Anthem.
- **STAT:** If an emergency situation exists and you can't wait for LabCorp's stat turnaround (three to four hours from the time the lab is called), you can mark "STAT" on your claim form for that lab procedure. However, Anthem will pay the lab charge only and will not pay for "STAT" fee charges.
- If the original claim doesn't denote "STAT" and is denied for payment because it should have been sent to LabCorp, Anthem will not pay at a later date even if the claim is resubmitted with "STAT" marked on it.
- **Cerebrospinal fluid/bone marrow aspirate:** Due to the labile nature of these specimens, Anthem recommends that they be transported to the nearest hospital for analysis. Please call LabCorp for information or instructions. This also helps with reporting results properly and obtaining written copies of the results.
- **Non-gynecologic cytology:** Place specimens such as urine, bladder washing, body fluids (peritoneal, gastric), cyst fluids and cerebrospinal fluids in a clean, leak-proof container with an equal volume of fifty percent (50%) alcohol.
- **Histology:** Place tissue in leak-proof biopsy bottles containing ten percent (10%) formalin in a volume five (5) times that of the specimen. Do not use a preservative if microbiological cultures are required.

LabCorp will contact providers if it receives inadequate, inappropriate, or improperly prepared or stored specimens.

Other Considerations

A physician or other health care provider may not bill for services sent to an outside lab. This includes cytopathology services for cervical cancer screening (Pap codes 88141-88175 and P3000-P3001). Codes 88141-88175 and P3000-P3001 are to be used by the laboratory performing the test, not by the physician obtaining the specimen. Effective with ClaimsXten implementation on November 14, 2009, Pap smear codes are denied when reported with E/M codes.

Q0091-Obtaining the specimen for cervical cancer screening is included in the allowance for and is thus incidental to the E/M or the preventive care visit service and is not reimbursed separately. Please refer to Reimbursement Policies: Bundled Services and Supplies, Modifier 59 and Screening Services with Evaluation and Management Services.

Specialized Anatomic Pathology

LabCorp is a leader in innovative diagnostic testing, with active research and development groups. Some of its specialized services include the following:

- A.P. triple screens
- AIDS-related testing, including genotype and phenotype analysis
- Allergy (RAST and Immunocap) testing
- Genetic/cytogenetic testing with board-certified cytogeneticists and genetic counselors available for consultation
- Tumor marker testing
- DNA probe testing

For information about specialized assays or about requirements for special collection kits and specimen handling, call LabCorp at 303-792-2600 or toll free at 888-LABCORP (888-522-2677).

LabCorp Patient Service Centers

To find a LabCorp location near you, go to www.LabCorp.com or call one of the phone numbers above.

Pharmacy Services

The information in this section applies to Anthem members with our prescription drug coverage.

Prescription Drug Benefit Design

Anthem has various prescription drug benefit designs. A member's cost is typically lower for a generic drug than for a brand-name medication.

Drug Category	Member Copayment
Generic X on formulary (tier 1)	Tier-1 - means a drug that has the lowest Copayment. This tier has low cost or preferred medications. This tier may include Generic Drugs, Single Source Drugs and Multi-Source Drugs.
Brand A formulary – no generic equivalent available (tier 2)	Tier-2 - means a drug that has a higher Copayment than those in tier 1. This tier has preferred medications that generally are moderate in cost.

Drug Category	Member Copayment
	This tier may include Generic Drugs, Single Source Drugs and Multi-Source Drugs.
Brand C non-formulary – no generic equivalent available (tier 3)	Tier-3 - means a drug that has a higher Copayment than those on tier 2. This tier may have non-preferred medications which are generally higher in cost. This tier may include Generic Drugs, Single Source Drugs, and Multi-Source Drugs.
Brand D non-formulary (tier 3) – generic equivalent available (tier 1)	Tier-3 - means a drug that has a higher Copayment than those on tier 2. This tier may have non-preferred medications which are generally higher in cost. This tier may include Generic Drugs, Single Source Drugs, and Multi-Source Drugs. + difference in cost between the brand and its generic equivalent + applicable copay
Tier 4	Tier-4 - means drugs with the highest Copayment. This tier has medications which are generally highest in cost. This tier may include Generic Drugs, Single Source Drugs, and Multi-Source Drugs.
Benefit exclusion examples: Some drugs, such as over-the-counter agents, sexual dysfunction agents, those used for cosmetic purposes, or Prescription Drugs that have a Clinically Equivalent alternative, even if written as a prescription.	Full cost of drug

Additional formulary/drug list information is available online. Anthem has multiple formulary/drug lists, please select the appropriate drug list when searching for covered medications. Please go to the following link on the Anthem provider Portal, under forms: <http://www.anthem.com/health-insurance/customer-care/forms-library>. You can also download information and updates to a handheld Palm Pilot at www.ePocrates.com.

[Tier 4 Medications](#)

Tier 4 medications must be obtained through the Anthem pharmacy network. The list of four-tier medications can be located online **at Anthem.com.** **Please go to the**

following link on the Anthem provider Portal, under forms:
<http://www.anthem.com/health-insurance/customer-care/forms-library>.

The list of Tier 4 medications is subject to change.

Pharmacy Benefit Drugs Requiring Authorization

Anthem's Pharmacy Benefit Manager is committed to helping Anthem's members manage their health care benefits. Prior authorization, quantity limits, step therapy and dose optimization are edits approved by Anthem's National Pharmacy and Therapeutics committee. These edits help ensure that members' benefits provide them with access to safe, appropriate and effective medications.

- **Prior authorization** may require a member to obtain approval before receiving benefits to cover the medication.
- **Step therapy** may require a member to use another type of medication first before receiving benefits for another medication.
- **Quantity limits** may affect the quantity of a certain medication a member can receive benefits for each month.
- **Dose optimization** (or dose consolidation) usually involves converting from a twice-daily dosing schedule to a once-daily dosing schedule. A once-daily dosing schedule may increase compliance and decrease expenses for the member and Anthem.

To request a prior authorization for a drug, please call the pharmacy prior authorization help desk at 866-310-3666.

A complete list of medications and prior authorization forms can be found at the following link via the Anthem.com provider website: <https://www.anthem.com/health-insurance/customer-care/forms-library>.

Clinically Equivalent Medications Program

Our insured business and a number of our other health plan clients no longer cover certain medications. We have begun excluding coverage for certain prescription drugs within a therapeutic class that don't provide the best value and which may have over-the-counter options available, and including coverage for less costly, clinically equivalent alternatives. For a complete list of medications under this program, please go to our forms library at the following link, <https://www.anthem.com/health-insurance/customer-care/forms-library>.

GenericSelect Program

GenericSelect allows current Anthem members to receive their first prescription of a select generic drug for no co-payment. The customer may have **one (1)** co-payment waived at mail and/or retail. This is a voluntary program. A list of current medications in the program can be obtained by calling the customer service department on the back of the member's health plan ID card. The retail portion of this program is available to **all** customers who are first time users of the selected generic medication. Customers can receive **one (1) thirty (30) day supply** of the same select generic medications at the retail pharmacy with the first co-payment waived. The mail program allows customers currently receiving a targeted brand medication to receive **one (1) ninety (90) day supply** of the select generic through the mail for no co-payment. Additional fills will be charged any applicable copayment. For a complete list of medications under this program, please go to out forms library at the following link, <https://www.anthem.com/health-insurance/customer-care/forms-library>.

Half-Tab Program

Anthem's Pharmacy Benefit Manager Half Tablet Program is designed to help customers save up to fifty percent (50%) on out-of-pocket costs for select medications by splitting tablets in half. Customers who participate in this voluntary program can expect to save immediately by either reducing their copayment or reducing their portion of coinsurance paid. This is a voluntary program and tablet splitters are provided. A list of current medications in the program can be obtained by calling the customer service department on the back of the member's health plan ID card. For a complete list of medications under this program, please go to out forms library at the following link, <https://www.anthem.com/health-insurance/customer-care/forms-library>.

Home Delivery Pharmacy Program

Anthem members can enroll in and use the Home Delivery Pharmacy program for up to a ninety (90) day supply of maintenance medications, used to treat chronic health conditions. With many Anthem prescription drug plans, our members usually have reduced copayments and can save money by using home delivery pharmacy. More information about the home delivery pharmacy program is available online. Please go to the following link on the Anthem website, under the forms library: <https://www.anthem.com/health-insurance/customer-care/forms-library>.

For new prescriptions, please order the "retail" quantity of no more than a thirty (30) day supply to minimize waste if the drug or dose needs to be changed, and then order a ninety (90) day supply via home delivery pharmacy once it's medically appropriate.

Specialty Pharmacy Services

Anthem's contracted Specialty Pharmacy is Anthem's preferred source for specialty prescription medications. For more information about specialty medications, please call

877-500-3701 toll free, or go to online to view the current specialty drug list. Please go to the following link on the Anthem website, under the forms library:
<http://www.anthem.com/health-insurance/customer-care/forms-library>.

We encourage you to use Anthem's Specialty Pharmacy to fill specialty prescriptions for your Anthem patients. It is a full-service specialty pharmacy that delivers specialty drugs to more than one (1) million people nationwide and provides case management services to patients taking specialty medications. Most Anthem prescription benefit plans **require** certain specialty medications be filled only by Anthem's Specialty Pharmacy.

Anthem's Specialty Pharmacy offers you and our members these personalized services and resources:

- A team of nurses, pharmacists and care coordinators who offer personal support related to the member's specialty medications and associated health care concerns
- Care coordinators who remind patients when it's time to refill their prescriptions and who'll coordinate delivery as requested
- A clinical case management team that understands our members' needs and can provide helpful information about their condition to support your treatment plan

To use Anthem's Specialty Pharmacy to fill specialty medications for your Anthem patients, you have two options:

1. **Call toll free at 877-500-3701.** A care coordinator will get the information that's needed to begin the prescription process. Care coordinators are available **from 6 a.m.-7 p.m. Mountain Time, Monday through Friday**. For TDD/TTY assistance, our members can call 800-221-6915 toll free from 6:30 a.m.-3 p.m. Mountain Time, Monday through Friday.
2. **Fax the prescription and a copy of the member's health plan ID card to Anthem's Specialty Pharmacy toll free at 800-824-2642.**

Pharmacy Benefit Management and Drug List/Formulary

Anthem's Pharmacy and Therapeutics Committee consists of two interdependent subcommittees – the Clinical Review Committee and the Value Assessment Committee. Together, the subcommittees work as a checks-and-balances system, helping to maintain a clinically based drug list/ formulary that offer's our members access to quality, affordable medications.

Clinical Review Committee ("CRC"): The CRC assigns clinical designations to medications. The designations are determined through review of current guidelines and treatment criteria from sources like major medical publications, professional journals, medical specialists, product package inserts, etc.

Value Assessment Committee (“VAC”): The VAC meets after the CRC has established the clinical foundation and rationale. Its role is to determine tier assignments, or coverage levels, for medications. To help ensure clinical guidelines are properly balanced with financial considerations, the VAC must take into account the CRC’s clinical designations when recommending medications for the Anthem national drug list/formulary. In addition to the designations assigned by the CRC, the VAC may also look at financial information (i.e., average wholesale price, rebates, ingredient cost, cost of care, copayments and coinsurance), market factors and the impact on members to determine tiers/levels. The VAC is responsible for creating tier assignments that appropriately balance the impact on clinical, financial and member considerations.

Additions to the Anthem drug list/formulary currently occur four (4) times a year. Formulary deletions can occur at least twice a year. For Anthem members to receive their highest level of benefits, all Providers and Facilities should use the drug list/formulary when prescribing medications. A copy of the drug list/formulary is available online. Go to the following link, <https://www.anthem.com/health-insurance/customer-care/forms-library>. You can also download information and updates to a handheld Palm Pilot at www.ePocrates.com.

To request addition of a medication to the Anthem drug list/formulary, please access the Drug List/Formulary online as indicated above, and select the following link http://www.anthem.com/forms/pharmacy/formulary_addition.html.

Behavioral Health and Chemical Dependency Rehabilitation Services

Anthem’s behavioral health operations acts as a facilitator for directing members to behavioral health and chemical dependency rehabilitation services and managing member care in accordance with the member’s needs, location and Health Benefit Plan coverage. Providers may refer members to Anthem’s behavioral health operations (although a referral isn’t required) at the numbers listed below to locate a Provider or Facility for behavioral health and chemical dependency rehabilitation services:

- All Local Plan members: 800-424-4014
 - Local Plan members are defined by referencing the [Alpha Prefix Reference List](#).
- FEP members: 800-424-4011
 - *FEP members are identified by the following alpha prefix:*
R + 8 numerics

Please note: Anthem’s behavioral health operations doesn’t manage behavioral health and chemical dependency rehabilitation services for BlueCard and national account members. For those members, please refer to the behavioral health/substance abuse phone number on the back of the member’s health plan ID card.

In emergency situations, please call 911 or direct the member to the nearest emergency facility. Anthem's behavioral health operations will also be available to direct you and the member to an appropriate facility or other provider for emergency services.

[Authorizations](#)

For behavioral health services that require authorizations, please see the Quick Reference Pre-certification Guide in the Referrals and Pre-certifications section of this Manual.

Psychotherapy Notes Authorization

Complete this form for release of psychotherapy notes from provider to Company. If member wishes to disclose clinical information and psychotherapy notes, member must complete both the Individual Authorization Form and Psychotherapy Notes Authorization.

Please find the most current copy of the Psychotherapy Notes Authorization form located online at anthem.com:

- Go to **anthem.com**. Select **Provider, Colorado** and **enter**. From the **Answers@Anthem** tab, select **Download Forms**, and then select the link titled "[Psychotherapy Notes Authorization](#)".

Individual Authorization Form

Complete this form for release of PHI and clinical information from provider to Company. If member wishes to disclose clinical information and psychotherapy notes, member must complete both the Individual Authorization Form and Psychotherapy Notes Authorization Form.

Please find the most current copy of the Individual Authorization Form located online at **anthem.com**:

- Go to **anthem.com**. Select **Provider, Colorado** and **enter**. From the **Answers@Anthem** tab, select **Download Forms**, and then select the link titled "[Individual Authorization Form](#)".

[Detoxification](#)

Detoxification services that can be appropriately managed in a behavioral health care substance abuse unit (the majority of all detoxification services) will be transferred to behavioral health care detoxification units and managed by Anthem's behavioral health operations. Anthem medical management will manage acute detoxification cases that require acute medical beds based on co-morbid medical conditions such as severe

cardiac arrhythmia, septicemia, electrolyte imbalance, GI bleeds, liver failure, diabetic coma, or other severe co-morbid condition.

Utilization Management

- Facility utilization review representatives or intake representatives will transfer detoxification cases to behavioral health care units, and they'll contact Anthem's behavioral health operations UM department at **800-424-4014** for pre-certification.
- For acute medical situations that require admission to an acute medical bed detoxification unit, facility utilization review representatives will continue to call Anthem medical management at **800-832-7850**.
- **Note:** FEP UM, available toll free at **800-424-4011**, will continue to manage detoxification services for all FEP members.

Anthem Behavioral Health Contact Information

Product Name	Reason for Call	Phone Numbers	Claims Submission Address	Alpha Prefix on Member ID Card
Anthem Blue Cross and Blue Shield (local PPO) Authorization not required for outpatient services	Intake/Authorization Claims/eligibility/benefits	800-424-4014 877- 833-5742	Anthem Blue Cross and Blue Shield Claims P.O. Box 5747 Denver, CO 80217-5747	PPO local: AGR, AKI, ARK, CBW, CLN, COG, CSS, CST, CUH, DQJ, DYY, EFM, ENH, EOW, EXE, FFW, FIV, FOW, FQJ, GRL, GVC, GXS, HKE, HQA, HTQ, KOS, LGQ, MOO, NIB, NMX, NOH, NQM, NRX, NWD, OAG, OHR, OLU, PEA, PQC, RNF, ROW, ROZ, RXY, SLE, TED, TGZ, TMC*, TZX (IND), UCL, UIT, ULA, ULX, UOW, UQC, UQJ, UZT, WOZ, WSR, WVY, WZT XFH, XFJ, XFK, XFL, XFM, XFP, XFT, XFW, XFZ
BlueCard® (out-of-state PPO) Authorization not required for outpatient services	Customer service/claims Eligibility/benefits: call the phone number on member ID card or:	888-817-3717 Use number on member's card		PPO: All other alpha prefixes not listed with other products
HMO Colorado Authorization required for first outpatient visit	Intake/ Authorization Claims/eligibility/benefits	800-424-4014 877- 833-5742		HMO: PQQ, TZX, UCD, UCF, UCV (HMO), VAA, VAB, VAC, VAD, VAE (Pathway Network – Large Group) , WPQ, XFA, XFD, XFF, XFI, XFN, XFS, XFV, XFX, XFY
HMOSelect Authorization required for first outpatient visit	Intake/Authorization Claims/eligibility/benefits	800-424-4014 877-833-5742		HMOSelect: XFB, XFC

Health Insurance Exchange (HIX): <i>(This unit handles both ON and OFF exchange plans that are Affordable Care Act (ACA) compliant)</i> <i>*(Off Exchange/ACA Compliant)</i>	Intake/Authorization Claims/eligibility/benefits	800-424-4014 855-854-1438		On Exchange: Pathway X Enhanced: VAB, VAC, XFV Off Exchange/ACA Compliant: VAA = Pathway Enhanced VAD = PPO XFI = Blue Priority (HMO) XFS = Blue Priority PPO XFX = Pathway Enhanced
FEP: FEP Standard Authorization required for first outpatient visit FEP Basic Authorization required for first outpatient visit	Customer service/authorization Claims/eligibility/benefits	800-424-4011 800-852-5957	FEP P.O. Box 105557 Atlanta, GA 30348-5557	R + 8 numerics


[Depression Pocket Guide](#)

Depression can affect 10 percent (10%) or more of the patients you will see in your office. Because PCPs treat more than 75 percent (75%) of depressed patients, we've added the pocket guide to provide you with a helpful tool for identifying depression in our members. These materials are adapted from the [Colorado Clinical Guidelines Collaborative](#) and have been endorsed by most major health plans in Colorado.

Depression Pocket Guide

CDSB Appendix 1: Antidepressant Classification and Dosages for Adults									
CDSB	Drug	Daily Starting Dosage	Usual Adult Dosage	Contraindications	Cautions	Pregnancy	Lactation	Other	Comments
Major	Amitriptyline	75 mg qd	150-225 mg qd	X	X	X	X	X	X
	Desipramine	75 mg qd	150-225 mg qd	X	X	X	X	X	X
	Doxepin	120 mg qd	120-360 mg qd	X	X	X	X	X	X
	Imipramine	75 mg qd	150-225 mg qd	X	X	X	X	X	X
	Nortriptyline	75 mg qd	150-225 mg qd	X	X	X	X	X	X
	Trimipramine	75 mg qd	150-225 mg qd	X	X	X	X	X	X
	Dothiepin	75 mg qd	150-225 mg qd	X	X	X	X	X	X
	Protriptyline	75 mg qd	150-225 mg qd	X	X	X	X	X	X
	Phenelzine	30 mg bid	60-90 mg bid	X	X	X	X	X	X
	Tranylcypromine	30 mg bid	60-90 mg bid	X	X	X	X	X	X
Minor	Fluoxetine	20 mg bid	20-60 mg bid	X	X	X	X	X	X
	Paroxetine	20 mg qd	20-60 mg qd	X	X	X	X	X	X
	Citalopram	10 mg bid	10-30 mg bid	X	X	X	X	X	X
	Escitalopram	10 mg bid	10-30 mg bid	X	X	X	X	X	X
	Sertraline	50 mg qd	50-200 mg qd	X	X	X	X	X	X
	Fluvoxamine	50 mg bid	50-150 mg bid	X	X	X	X	X	X
	Venlafaxine	75 mg bid	75-225 mg bid	X	X	X	X	X	X
	Duloxetine	30 mg bid	30-60 mg bid	X	X	X	X	X	X
	Levomelevatine	30 mg bid	30-60 mg bid	X	X	X	X	X	X
	Desvenlafaxine	30 mg bid	30-60 mg bid	X	X	X	X	X	X

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Major Depression Disorder in Adults

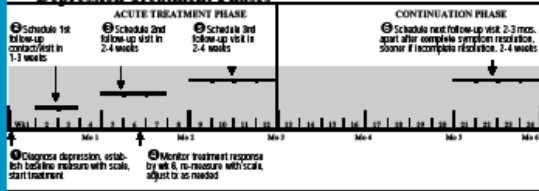
DIAGNOSIS & TREATMENT GUIDELINES

It is estimated that 10% of Americans (~26 million people) suffer from major depression and related mood disorders. Only one third to one-half of these patients are correctly diagnosed and treated initially, and up to 60% discontinue therapy before completing the recommended 6-month course. Inadequately treated depression creates a substantial social and emotional burden on both the patient and society, and costs billions of dollars per year in absenteeism and lost work productivity.

5 A's of Depression

- ASK** all patients:
 - In the past month, have you had little interest or pleasure in doing things?
 - In the past month, have you felt down, depressed, or hopeless?
- ASSESS** severity of the depression using DSM-IV criteria (PHQ-9, QIDS and other tools may be helpful for this). Assess:
 - Recent life events (Why is this an issue now?)
 - Personal history of depression or bipolar disorder
 - Family history of depression or bipolar disorder
 - Substance abuse
 - Risk of suicide (plans, attempts, recent exposure to suicide)
- ADVISE** patient about:
 - Treatment options
 - Possible side effects
 - Importance of compliance
- ASSIST** patient by providing (as indicated):
 - Patient education about depression and treatment
 - Counseling or referral to a practitioner at the appropriate level of care
 - A prescription for antidepressant medication
 - Crisis intervention
- ARRANGE** follow-up care:
 - Initially, within 1-3 weeks. Contact within one week may be helpful to assess side effects or compliance.
 - Then ongoing, to monitor success, failure or partial response

Depression Treatment Phases



ACUTE TREATMENT PHASE

- Schedule 1st follow-up visit in 1-3 weeks
- Schedule 2nd follow-up visit in 2-4 weeks
- Schedule 3rd follow-up visit in 2-4 weeks

CONTINUATION PHASE

- Schedule next follow-up visit 2-3 months after complete symptom resolution. Shorter if incomplete resolution. 3-4 weeks

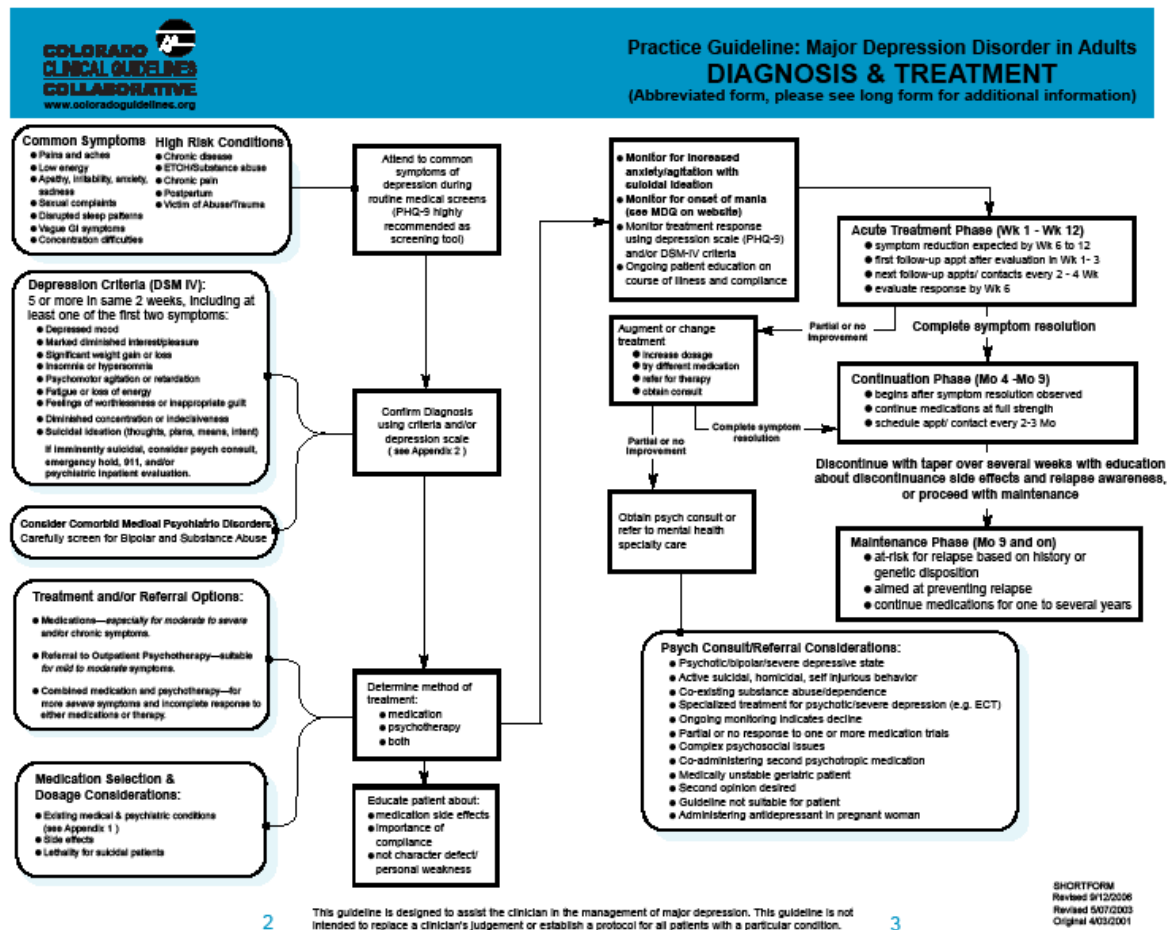
Legend:

- Diagnose depression, establish baseline measures with scales, start treatment
- Monitor treatment response by wk 6, re-assess with scales, adjust tx as needed

For references, medical record tracking forms and additional color copies of the guideline, go to www.coloradoguidelines.org OR call 720-297-1681 OR 866-401-2092 (toll free).

1

Depression Pocket Guide - continued



Chiropractic, Acupuncture, Massage and Nutritional Therapy Services

Anthem is contracted with Landmark Healthcare ("Landmark") as its statewide provider for chiropractic, acupuncture, massage and nutritional therapy services. All Landmark providers are listed on our provider directory at **anthem.com**. Provider demographic changes and Provider administrative grievances should be directed to Landmark Healthcare for all lines of business at 800-638-4557.

PPO and Indemnity

Members must use the Landmark network to receive in-network coverage. Services **do not** require an authorization. Please contact Anthem for eligibility/benefits/claims information. **Please send claims to Anthem.** Please see the Telephone/Address Directory section for phone and address information.

[HMO \(Chiropractic, Acupuncture and Massage Therapy\)](#)

Members must use the Landmark network. Services don't require a referral but must be authorized by Landmark. Please call Landmark for eligibility/benefits/claims information at 800-638-4557. **Please send claims to Landmark.**

For Chiropractic, Acupuncture and Massage Therapy HMO claims, send to:

Landmark Healthcare
1750 Howe Ave., Suite 300
Sacramento, CA 95825-3369

All claims for Nutritional Therapy (including HMO) should go directly to Anthem.

Workers' Compensation Program

[Workers' Compensation](#)

Workers' compensation coverage is based on the philosophy that employers should provide employees with injury protection as a cost of doing business, and that benefits should be provided without regard to the at-fault party when an injury occurs during the course of employment. Anthem has created a network that will join together a group of health care professionals to provide medical care to injured workers. This approach allows employees and members to essentially use the same network for both occupational and non-occupational treatment. Anthem's workers' compensation services unit will provide network access, bill review, case management and utilization review services to insurance companies, third-party administrators ("TPAs") and self-insured employers in Colorado. This can help employers control the health care costs of an injured worker's claim. If you participate in this network, injured workers will be channeled to you for treatment via referrals from our contracted ancillary networks or claims examiners.

[Provider Guidelines](#)

The provider should question a member seeking medical treatment when the nature of the illness or injury appears to be work-related. Some employers insist that all workers' compensation cases be handled through their private workers' compensation physicians and only when authorized; these employers won't reimburse any other physician, hospital, facility or other health care professional service. The provider should determine whether the member's illness or injury is:

- A non-emergency. Instruct the member to get authorization from the employer before providing treatment.
- An emergency. If a member requires emergency treatment, care must be provided to the injured person. Determining workers' compensation coverage

should be made within the next seventy-two (72) hours. The provider can then collect from the workers' compensation insurance carrier.

If a member is covered for workers' compensation benefits by a participating workers' compensation carrier permissibly, or if a self-insured employer contracting with Anthem seeks services for a work-related illness or injury, the provider has the following options:

- 1) provide such Medically Necessary medical services, or
- 2) refer the member to a health care professional that participates in the Anthem occupational medicine network. If the provider elects to treat the member, the provider must complete a Doctors First Report of Injury, as defined in the Workers' Compensation Act of Colorado.

As payment for the medical services rendered, the provider agrees to accept, as payment in full, compensation in accordance with the reimbursement set forth in the Agreement.

Send all workers' compensation-related correspondence to:

Anthem Blue Cross and Blue Shield – WCS for Colorado
2170 Towne Center Drive, Suite 320
Anaheim, CA 92806

You can reach customer service for bill review at 800-422-7334 and select option #2. Hours of operation are 9 a.m. to 6 p.m. Mountain Time. Voice mail is available if you call this number after hours.

[Utilization Management Guidelines](#)

The utilization management guidelines are those set by the Workers' Compensation Act of Colorado. If you have questions about these guidelines, please contact the Workers' Compensation Division. If you have questions about the utilization management process, please call us at 800-422-7334.

[Workers' Compensation Act of Colorado Standards](#)

The Workers' Compensation Act of Colorado has established standards for injured workers for accessing care and guidelines to improve the quality of medical care for occupational injuries. Providers and Facilities must adhere to the following guidelines:

- Maintain medical control for the life of the claim.
- Make referrals to providers in the participating and PPO occupational medicine network. To find providers in this network, call 800-422-7334.
- Services obtained outside the network may not be paid. Contact the claims adjuster for authorization for any medical care outside the network.

- After the initial visit, the injured worker can change to any physician of his or her choice within the network.
- Submit claims to the appropriate workers' compensation administrator as soon as possible after providing health care services. The Explanation of Review will indicate that rates are in accordance with your Anthem Agreement.
- Prohibit any surcharges or other billings in violation of the Labor Code for workers' compensation health care services.

The claims administrator will ensure payment for authorized medical services rendered while a claim is under investigation, until such time as the claims administrator denies the claim.

[Anthem Workers' Compensation Payers Accessing the Participating and PPO Occupational Medicine Network](#)

For the most current list of participating payers, go to anthem.com, click Plans and Benefits, and select the Workers' Compensation tab. We'll update this online list monthly, by the fifth of each month.

[Rules for Calculating Permanent Disability](#)

The calculation of permanent disability is to be in accordance with the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition. You can get Information about this guideline at www.ama-assn.org.

If you feel you're unable to write the permanent and stationary report, contact the claims examiner to refer the patient to another physician to prepare a report utilizing the guideline.

[Grievances](#)

A complaint and grievance process is available. Please call 800-422-7334 for more information.

[Additional Information](#)

For more information about the obligations of the treating physician for workers' compensation, go to the Colorado Division of Labor and Employment website at www.coworkforce.com/dwc, or call us at 800-422-7334.

Glossary

Admission Notification – Notice to the health plan about an urgent or emergent (unscheduled) admission

Alpha Prefix – The three characters preceding the subscriber ID number on Blue Cross and/or Blue Shield health plan ID cards. The alpha prefix is required for system-wide claims routing and identifies the member's Blue Cross and/or Blue Shield plan or national account.

anthem.com – Anthem's website, where the Provider Policy and Procedure Manual can be viewed online

Authorization – Approval of benefits for a member's covered procedure or service

Away from Home Care[®] Program – Provides HMO members with health insurance coverage for urgent and emergent (life-threatening) medical services when an unforeseen illness or injury occurs while they're away from their Blue Cross and/or Blue Shield HMO plan's service area.

Away from Home Care Program Guest Membership Benefit – Health insurance coverage for HMO members from other Blue Cross and/or Blue Shield plans who are staying in Colorado temporarily (but more than three months). This coverage is available through HMO Colorado, and guest membership coverage is based on BlueAdvantage HMO guidelines and benefits.

bcbs.com – The Blue Cross and Blue Shield website, which providers and members can use to locate Providers or Facilities with any Blue Cross and/or Blue Shield plan. This website is useful when a provider needs to refer a member to a provider in another location.

BlueCard Access – A toll-free telephone number, 800-810-BLUE (2583), Providers and members can call to locate providers contracted with any Blue Cross and/or Blue Shield plan. This number is useful when a provider needs to refer a member to a provider in another location.

BlueCard Eligibility – A toll-free telephone number, 800-676-BLUE (2583), Providers can call to verify membership and coverage information for members from other Blue Cross and/or Blue Shield plans.

BlueCard HMO – An out-of-area program available to members of Blue Cross and/or Blue Shield plan-sponsored HMOs. This program provides for urgent, emergent and pre-certified follow-up care.

BlueCard PPO – A national program that offers PPO-level benefits to members traveling or living outside their Blue Cross and/or Blue Shield plan's service area. They must obtain the services from a physician or hospital designated as a BlueCard PPO Provider.

BlueCard PPO Member – Members whose health plan ID card contains the “PPO in a suitcase” identifier. Only members with this identifier can access BlueCard PPO benefits

BlueCard Program – A national program that provides members with access to BlueCard providers and savings. The program enables members to obtain health care services while traveling or living in another Blue Cross and/or Blue Shield plan's area and to receive the same benefits as those under their contracting Blue Cross and/or Blue Shield plan. The program links participating health care providers and the independent Blue Cross and/or Blue Shield plans across the country through a single electronic network for claims processing and reimbursement. The program allows providers to submit claims for BlueCard members, including those located outside the United States, directly to the provider's local Blue Cross and/or Blue Shield plan.

BlueCard Provider Finder Website (www.bcbs.com) – A website providers and members can use to locate Providers and Facilities with any Blue Cross and/or Blue Shield plan. This website is useful when a provider needs to refer a member to a provider in another location.

BlueCard Worldwide® – A program that allows Blue Cross and/or Blue Shield members traveling or living outside the United States to receive inpatient, outpatient and professional services from Providers and Facilities worldwide. The program also allows members of international Blue Cross and/or Blue Shield plans to access Blue Cross and/or Blue Shield provider networks in the United States.

Clinical Utilization Management (“UM”) Guideline – Clinical UM Guidelines serve as one of the sets of guidelines for coverage decisions. These guidelines address the Medical Necessity of existing, generally accepted services and/or procedures. The services include, but are not limited to, devices, biologics and specialty pharmaceuticals, and behavioral health services.

Concurrent Review – Conducted to monitor ongoing care in an institutional setting to determine if clinical services and treatment plans continue to meet guidelines for the level of care the member is receiving

Contractual Adjustment – Any portion of a charge for a covered service that exceeds Anthem's contracted allowed amount/maximum benefit allowance. Providers can't charge contractual adjustments to members or to Anthem.

Coordination of Benefits (“COB”) – A stipulation in most health insurance policies that helps prevent duplicate payments for services covered by more than one insurance policy or program. The COB stipulation outlines which insurance organization has

primary responsibility for payment and which insurance organization has secondary responsibility for payment.

Electronic Data Interchange (“EDI”) – The computer-application-to-computer-application exchange of business information in a standard electronic format. Translation software aids in exchange by converting data extracted from the application database into standard EDI format for transmission to one or more trading partners.

Exclusive Provider Organization (“EPO”) – A more rigid type of Health Maintenance Organization (HMO) health benefit program that provides benefits only if care is rendered by providers who belong to an identified network

Experimental/Investigational –

- (a) Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation or treatment of a disease, injury, illness or other health condition which we determine in our sole discretion to be experimental or investigational.

We will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply to be experimental or investigational if we determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought.

The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (“FDA”) or any other state or federal regulatory agency, and such final approval has not been granted
- Has been determined by the FDA to be contraindicated for the specific use
- Is provided as part of a clinical research protocol or clinical trial, or is provided in any other manner that is intended to evaluate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or is subject to review and approval of an Institutional Review Board (“IRB”) or other body serving a similar function
- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as experimental or investigational, or otherwise indicate that the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is under evaluation

(b) Any service not deemed experimental or investigational based on the criteria in subsection (a) may still be deemed to be experimental or investigational by us. In determining whether a service is experimental or investigational, we will consider the information described in subsection (c) and assess all of the following:

- Whether the scientific evidence is conclusory concerning the effect of the service on health outcomes
- Whether the evidence demonstrates that the service improves the net health outcomes of the total population for whom the service might be proposed as any established alternatives
- Whether the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings

(c) The information we consider or evaluate to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is experimental or investigational under subsections (a) and (b) may include one or more items from the following list, which is not all-inclusive:

- Randomized, controlled, clinical trials published in authoritative, peer-reviewed United States medical or scientific journal
- Evaluations of national medical associations, consensus panels and other technology evaluation bodies
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply
- Documents of an IRB or other similar body performing substantially the same function
- Consent documentation(s) used by the treating physicians, other medical professionals or facilities, or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply
- The written protocol(s) used by the treating physicians, other medical professionals or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply
- Medical records

- The opinions of consulting providers and other experts in the field
- (d) We have the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is experimental or investigational.

Health Benefit Plan – The document(s) describing the partially or wholly insured, underwritten and/or administered health care benefits or services program between the plan and an employer, an individual, or a government or other entity; or, in the case of a self-funded arrangement, the plan document that describes the Covered Services for a member.

Health Maintenance Organization (HMO) – A health benefit program that offers benefits to members when they obtain services from the network of physicians and hospitals designated as HMO Providers and Facilities. Benefits are eliminated when the member obtains care from a non-HMO provider, except for emergency services and authorized referrals. Generally, HMO members select a primary care provider.

HIPAA – The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191

Maximum Benefit Allowance (“MBA”) – “Maximum Benefit Allowance” means the maximum amount of reimbursement allowed for a Covered Service as determined by Anthem.

Medically Necessary or Medical Necessity – means the definition set forth in the member's Health Benefit Plan, unless a different definition is required by statute or regulation.

Medical Policy – Medical Policies serve as one of the sets of guidelines for coverage decisions. Medical Policies address the Medical and/or Investigational policy position statements or clinical indications for certain new medical services and/or procedures or for new uses of existing services and/or procedures. The services include, but are not limited to, devices, biologics and specialty pharmaceuticals, and behavioral health services.

Participating and PPO Occupational Medicine Network – The network of health care providers, including facilities and ancillary providers, that have contracted with Anthem and/or one or more of its affiliates and other payers to provide compensable medical care for prospectively determined rates to injured workers.

Participating and PPO Occupational Medicine Network Provider – A facility, medical group practice, participating physician or other ancillary provider that has contracted with Anthem and/or one or more of its affiliates and other payers to provide compensable medical care for prospectively determined rates to injured workers.

Pay, Paid or Payment – to contractually settle a debt or obligation. After the maximum benefit allowance is determined, Anthem or the employer’s benefit plan will satisfy its portion of the bill by payment to the provider. The member’s portion of the payment includes a deductible, copayment and/or coinsurance, or other cost-sharing amounts, and, if the provider is non-participating, any amounts over the maximum benefit allowance. The amount Anthem pays a provider may not be the same as the allowable amount shown on the member’s EOB or on the provider’s bill.

Pre-certification – Authorization given before either an inpatient admission or outpatient procedure or service (a.k.a., prior authorization and/or pre-authorization)

Preferred Provider Organization (PPO) – A health benefit program under which members receive a higher level of benefits by receiving services from providers in an identified network.

Pre-service Decision – A review of medical care or services that Anthem conducts, in whole or in part, before a member obtains the medical care or services (e.g., prospective review). Pre-certification and pre-authorization are pre-service decisions.

Post-service Decision – Any review by Anthem of medical care or services already provided to a member (e.g., retrospective review).

Primary Care Physician (“PCP”) – A physician who has entered into a written Agreement with Anthem to provide Covered Services to members and to coordinate and arrange for the provision of other health care services to members who have selected the physician as their PCP. A PCP is defined as one of the following specialties, Pediatrician, Family Practice, General Practice and/or Internal Medicine.

Prior Benefit Authorization (“PBA”) – A determination made before a member receives certain services that meet all eligible-for-coverage criteria and that the services comply with the provisions of the member’s Health Benefit Plan.

Provider – A health care professional, institutional health care provider, ancillary provider, hospital or any other entity that has entered into a written Agreement with Anthem to provide Covered Services to members, including upon appropriate referral, if necessary, by the member’s PCP and/or Anthem. A non-participating provider is a provider who hasn’t entered into such an Agreement.

Provider Policy and Procedure Manual – Prepared by Anthem and which Anthem may amend solely at its discretion. This Manual sets forth the basic policies and procedures to be followed by providers in carrying out the terms and conditions of their Agreement with Anthem. The terms of the Provider Policy and Procedure Manual are part of such an Agreement.

Prudent Lay Person Law – State of Colorado Regulation 4-2-17, titled “Prompt Investigation of Health Plan Claims Involving Utilization Review”

Referral – Authorization given to a member by the member’s PCP for an office visit with another provider. Referrals don’t cover procedures performed outside the provider’s office or invasive procedures performed in the provider’s office.

Reimbursement Policy (Professional) – Professional Reimbursement Policies are a set of policies developed to document coding and pricing methodologies as well as clinical editing for certain specific services.

Retrospective Review – Conducted to evaluate the appropriateness of services and level of care after services have been rendered. Review may occur before or after the initial payment determination.

Subscriber Liability – The amount the subscriber (member) must pay the provider, such as deductibles, coinsurance and copayments, to satisfy contractual cost-sharing obligations.

Utilization Review – A set of formal techniques designed to monitor the use, or evaluate the clinical necessity, appropriateness, efficacy or efficiency, of health care services, procedures or settings. Techniques include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning and/or retrospective review. Utilization review also includes reviews to determine coverage. This is based on whether or not a procedure or treatment is considered experimental/investigational in a given circumstance (except if it’s a specific exclusion under the member’s Health Benefit Plan) and review of a member’s medical circumstances when necessary to determine if an exclusion applies in a given situation.

Exhibits

[Download Commonly Requested Forms](#)

Download our commonly requested forms online. Go to **anthem.com**, select the **Provider** link in top center of the page. Select **Colorado** from drop down list and **enter**. Under the **Answers@Anthem** tab, select [Download Commonly Requested Forms](#). Downloads forms such as the following:

- **Claim Action Request Form**
- **Coordination of Benefits (COB) Questionnaire**
- **Designation of an Authorized Representative (DOR Form)**
- **Fax Authorization Form**

- Individual Authorization Form
- Medical-Surgical Clinical Data Submission
- Member Liability Waiver Form
- Provider Maintenance Form
-
- Provider Dispute Resolution Form
- Provider Refund Adjustment Request
- ProviderAccess Account Administrator Change Form
- ProviderAccess Account Agreement
- Psychotherapy Notes Authorization Form
- Urgent Care or Walk-In Doctor's Office Information
- W-9 Form

Appendices

Links

[BlueCard® Website](#)

[Centers of Medical Excellence \("CME"\) Transplant Provider Manual](#)

[Contact Us](#)

[Federal Employee Program \("FEP"\) Website](#)

[List of Affiliates](#)

[Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements](#)

[Medicare Advantage](#)
