VIRGINIA FACILITY PROVIDER MANUAL

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Introduction and Guide to Manual

Purpose and Introduction

Anthem Blue Cross and Blue Shield in Virginia is committed to working with Facilities and Covered Individuals to provide a high level of satisfaction in delivering quality care. The Anthem Facility Provider Manual is an integral part of this commitment, providing information on key contractual terms, products, eligibility, Claims submission, coverage guidelines and a directory of resources.

In summary, this manual communicates administrative and billing requirements. As Anthem makes changes to these requirements, this Manual will serve as a vehicle for communicating these changes.

Future Updates

Anthem is committed to providing contracted Facilities with an accurate and up-to-date Facility Provider Manual; however, there may be instances where new procedures or processes are not immediately reflected in the manual. In such cases, Anthem will make every effort to distribute updated documentation in the next manual update. In those instances when Anthem determines that information in this manual differs from that in the Agreement, the Agreement will take precedence over the Manual.

Legal and Administrative Requirements Overview

Fair Business Practice Act (FBPA)

***Please note this section does not apply to Medicaid or Medicare related business.*

§ 38.2-3407.15. Ethics and fairness in carrier business practices.

A. As used in this section:

"Carrier," "enrollee" and "provider" shall have the meanings set forth in § 38.2-3407.10; however, a "carrier" shall also include any person required to be licensed under this title which offers or operates a managed care health insurance plan subject to Chapter 58 (§ 38.2-5800 et seq.) of this title or which provides or arranges for the provision of health care services, health plans, networks or provider panels which are subject to regulation as the business of insurance under this title.

"Claim" means any bill, claim, or proof of loss made by or on behalf of an enrollee or a provider to a carrier (or its intermediary, administrator or representative) with which the provider has a provider contract for payment for health care services under any health plan; however, a "claim" shall not include a request for payment of a capitation or a withhold.

"Clean claim" means a claim (i) that has no material defect or impropriety (including any lack of any reasonably required substantiation documentation) which substantially prevents timely payment from being made on the claim or (ii) with respect to which a carrier has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with this section.

"Health care services" means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.

"Health plan" means any individual or group health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, managed care health insurance plan, or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, to cover all or a portion of the cost of persons receiving covered health care services, which is subject to state regulation and which is required to be offered, arranged or issued in the Commonwealth by a carrier licensed under this title. Health plan does not mean (i) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. or Title XX of the Social Security Act, 42 U.S.C. § 1397 et seq. (Medicaid), 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. (CHAMPUS); or (ii) accident only, credit or disability insurance, long-term care insurance, CHAMPUS supplement, Medicare supplement, or workers' compensation coverages.

"Provider contract" means any contract between a provider and a carrier (or a carrier's network, provider panel, intermediary or representative) relating to the provision of health care services.

"Retroactive denial of a previously paid claim" or "retroactive denial of payment" means any attempt by a carrier retroactively to collect payments already made to a provider with respect to a claim by reducing other payments currently owed to the provider, by withholding or setting off against future payments, or in any other manner reducing or affecting the future claim payments to the provider.

B. Subject to subsection H, every provider contract entered into by a carrier shall contain specific provisions which shall require the carrier to adhere to and comply with the following minimum fair business standards in the processing and payment of claims for health care services:

1. A carrier shall pay any claim within 40 days of receipt of the claim except where the obligation of the carrier to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by specific information available for review by the person submitting the claim that:

   a. The claim is determined by the carrier not to be a clean claim due to a good faith determination or dispute regarding (i) the manner in which the claim form was completed or submitted, (ii) the eligibility of a person for coverage, (iii) the responsibility of another carrier for all or part of the claim, (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which services were accessed or provided; or

   b. The claim was submitted fraudulently.

   Each carrier shall maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim shall be entitled to inspect such record on request and to rely on that record or on any other admissible evidence as proof of the fact of receipt of the claim, including without limitation electronic or facsimile confirmation of receipt of a claim.

2. A carrier shall, within 30 days after receipt of a claim, request electronically or in writing from the person submitting the claim the information and documentation that the carrier reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim. Upon receipt of the additional information requested under this subsection necessary to make the original claim a clean claim, a carrier shall make the payment of the claim in compliance with this section. No carrier may refuse to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits if the carrier fails timely to notify or attempt to notify the person submitting the claim of the matters identified above unless such failure was caused in material part by the person submitting the claims; however,

nothing herein shall preclude such a carrier from imposing a retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim would violate subdivision 6 of this subsection. Nothing in this subsection shall require a carrier to pay a claim which is not a clean claim.

3. Any interest owing or accruing on a claim under § 38.2-3407.1 or 38.2-4306.1 of this title, under any provider contract or under any other applicable law, shall, if not sooner paid or required to be paid, be paid, without necessity of demand, at the time the claim is paid or within 60 days thereafter.

4.

   a. Every carrier shall establish and implement reasonable policies to permit any provider with which there is a provider contract (i) to confirm in advance during normal business hours by free telephone or electronic means if available whether the health care services to be provided are medically necessary and a covered benefit and (ii) to determine the carrier's requirements applicable to the provider (or to the type of health care services which the provider has contracted to deliver under the provider contract) for (a) pre-certification or authorization of coverage decisions, (b) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim, (c) provider-specific payment and reimbursement methodology, coding levels and methodology, downcoding, and bundling of claims, and (d) other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract, including determining whether a claim is a clean claim. If a carrier routinely, as a matter of policy, bundles or downcodes claims submitted by a provider, the carrier shall clearly disclose that practice in each provider contract. Further, such carrier shall either (i) disclose in its provider contracts or on its website the specific bundling and downcoding policies that the carrier reasonably expects to be applied to the provider or provider's services on a routine basis as a matter of policy or (ii) disclose in each provider contract a telephone or facsimile number or e-mail address that a provider can use to request the specific bundling and downcoding policies that the carrier reasonably expects to be applied to that provider or provider's services on a routine basis as a matter of policy. If such request is made by or on behalf of a provider, a carrier shall provide the requesting provider with such policies within 10 business days following the date the request is received.

   b. Every carrier shall make available to such providers within 10 business days of receipt of a request, copies of or reasonable electronic access to all such policies which are applicable to the particular provider or to particular health care services identified by the provider. In the event the provision of the entire policy would violate any applicable copyright law, the carrier may instead comply with this subsection by timely delivering to the provider a clear explanation of the policy as it applies to the provider and to any health care services identified by the provider.

5. Every carrier shall pay a claim if the carrier has previously authorized the health care service or has advised the provider or enrollee in advance of the provision of health care services that the health care services are medically necessary and a covered benefit, unless:

   a. The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized; or

   b. The carrier's refusal is because (i) another payor is responsible for the payment, (ii) the provider has already been paid for the health care services identified on the claim, (iii) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to the carrier by the provider, enrollee, or other person not related to the carrier, or (iv) the person receiving the health care services was not eligible to receive them on the date of service and the carrier did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status.

6. No carrier may impose any retroactive denial of a previously paid claim unless the carrier has provided the reason for the retroactive denial and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because the provider was already paid for the health care services identified on

the claim or the health care services identified on the claim were not delivered by the provider, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed the lesser of (a) 12 months or (b) the number of days within which the carrier requires under its provider contract that a claim be submitted by the provider following the date on which a health care service is provided. Effective July 1, 2000, a carrier shall notify a provider at least 30 days in advance of any retroactive denial of a claim.

7. Notwithstanding subdivision 6 of this subsection, with respect to provider contracts entered into, amended, extended, or renewed on or after July 1, 2004, no carrier shall impose any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought. The written communication shall also contain an explanation of why the claim is being retroactively adjusted.

8. No provider contract may fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis and (ii) all material addenda, schedules and exhibits thereto and any policies (including those referred to in subdivision 4 of this subsection) applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract.

9. No amendment to any provider contract or to any addenda, schedule, exhibit or policy thereto (or new addenda, schedule, exhibit, or policy) applicable to the provider (or to the range of health care services reasonably expected to be delivered by that type of provider) shall be effective as to the provider, unless the provider has been provided with the applicable portion of the proposed amendment (or of the proposed new addenda, schedule, exhibit, or policy) at least 60 calendar days before the effective date and the provider has failed to notify the carrier within 30 calendar days of receipt of the documentation of the provider's intention to terminate the provider contract at the earliest date thereafter permitted under the provider contract.

10. In the event that the carrier's provision of a policy required to be provided under subdivision 8 or 9 of this subsection would violate any applicable copyright law, the carrier may instead comply with this section by providing a clear, written explanation of the policy as it applies to the provider.

11. All carriers shall establish, in writing, their claims payment dispute mechanism and shall make this information available to providers.

C. Without limiting the foregoing, in the processing of any payment of claims for health care services rendered by providers under provider contracts and in performing under its provider contracts, every carrier subject to regulation by this title shall adhere to and comply with the minimum fair business standards required under subsection B, and the Commission shall have the jurisdiction to determine if a carrier has violated the standards set forth in subsection B by failing to include the requisite provisions in its provider contracts and shall have jurisdiction to determine if the carrier has failed to implement the minimum fair business standards set out in subdivisions B 1 and B 2 in the performance of its provider contracts.

D. No carrier shall be in violation of this section if its failure to comply with this section is caused in material part by the person submitting the claim or if the carrier's compliance is rendered impossible due to matters beyond the carrier's reasonable control (such as an act of God, insurrection, strike, fire, or power outages) which are not caused in material part by the carrier.

E. Any provider who suffers loss as the result of a carrier's violation of this section or a carrier's breach of any provider contract provision required by this section shall be entitled to initiate an action to recover actual damages. If the trier of fact finds that the violation or breach resulted from a carrier's gross negligence and willful conduct, it may increase damages to an amount not exceeding three times the actual damages sustained. Notwithstanding any other provision of law to the contrary, in addition to any damages awarded, such provider also may be awarded reasonable attorney's fees and court costs. Each claim for payment which

is paid or processed in violation of this section or with respect to which a violation of this section exists shall constitute a separate violation. The Commission shall not be deemed to be a "trier of fact" for purposes of this subsection.

F. No carrier (or its network, provider panel or intermediary) shall terminate or fail to renew the employment or other contractual relationship with a provider, or any provider contract, or otherwise penalize any provider, for invoking any of the provider's rights under this section or under the provider contract.

G. This section shall apply only to carriers subject to regulation under this title.

H. This section shall apply with respect to provider contracts entered into, amended, extended or renewed on or after July 1, 1999.

I. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to implement this section.

J. If any provision of this section, or the application thereof to any person or circumstance, is held invalid or unenforceable, such determination shall not affect the provisions or applications of this section which can be given effect without the invalid or unenforceable provision or application, and to that end the provisions of this section are severable.

K. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.

(1999, cc. 709, 739; 2004, c. 425; 2005, c. 349.)

Insurance Requirements

A. Network/Participating Providers shall, during the term of this Agreement, keep in force with insurers having an A.M. Best rating of A minus or better, the following coverage:

1. Professional liability/medical malpractice liability insurance with limits of not less than $1,000,000 per claim and $3,000,000 in the aggregate which shall pay for claims arising out of acts, errors or omissions in the rendering or failure to render the services to be obtained under this Agreement. 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, Network/Participating Provider agrees to furnish and maintain an extended period reporting endorsement ("tail policy") for the term of not less than three (3) years in the amount not less than the per claim and aggregate values indicated above. Professional liability/medical malpractice limits may be satisfied with a combination of primary and excess coverage. Additionally, in states with patient compensation funds, a Network/Participating Provider may have less insurance coverage if the patient compensation fund, when considered with Network/Participating Provider's insurance and any applicable limits on damage awards, provides equivalent coverage.

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

3. 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 professional 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 Network/Participating Provider 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. Network/Participating Provider 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.

Point of Care

About Point of Care

Participating Facilities have fast, easy access to information about Covered Individuals and Claims –Monday through Saturday 6 a.m. until 12 midnight and Sunday from 6 a.m to 1 p.m. and 8 p.m. until 12 midnight. Simply log on to www.Anthem.com and click on Point of Care. You can access the following types of information:

- Eligibility & Benefits
- Claims Inquiry
- Claim Adjustment Request
- Weekly Remittances
- Authorizations (Inquiry & Create)
- Proof of Loss Claim Error Notification Report
- On-line Portal Registration

Other valuable resources (anthem.com)

Anthem.com offers an overview page that includes Medical Coverage Guidelines. In addition, information regarding the following is also available on our web site:

- EDI Information
- Utilization Review Information
- Remit remark codes
- Preventive Care List
- Health Services Review
- Commonly Used Forms
- 360° Health
- Health Programs
- Plans and benefits
- Health care Decision Tool

Claims Submission

Where and When to File Claims

Where to File Claims

Anthem typically accepts electronic or paper Claims. Check with each Plan to determine whether the Affiliate has electronic Claims capability. If so, file to Anthem and we will electronically route your Claims to the appropriate processing area.

Anthem provides a Companion Guide, which supplements the billing guidelines, to assist Network/Participating Providers with filing electronic Claims. If you would like to learn more refer to the Companion Guide located on our

web site at www.Anthem.com. For complete details – just select "Virginia" under the provider section and click on "Enter Site". Next select the "EDI" link and then the "Companion Guide" link. Refer to the table of contents for particular topics.

Unless specified otherwise, mail all Claims for all products to the following address. This includes Commercial, HMO, Medicaid, and Medicare Advantage.

Anthem Blue Cross and Blue Shield
P.O. Box 27401
Richmond, Virginia 23279

When to File Claims ("Timely Filing")

When Anthem provides coverage, Facilities must submit Claims no later than twelve (12) months after the date of service. If a Claim is denied because the filing period has expired, neither the Covered Individual nor the Plan is responsible for payment of the Facility's bill.

What Network/Participating Providers Can Collect as Payment

Facilities can collect the following payments:

- From Anthem - The Anthem Rate (minus any applicable Cost Share)
- From the HMOs - The Anthem Rate (minus any applicable Cost Share). The Network/Participating Provider may not collect any additional amounts from the HMOs.
- From any Covered Individual - All applicable patient pay items including, without limitation, Cost Shares.
- From a non-HMO Covered Individual - Payment for non-Covered Services, except for those denied as not Medically Necessary unless the Network/Participating Provider advises the Covered Individual in writing before the Health Services are rendered that the specific Health Service to be provided is not Medically Necessary and that the Covered Individual will be responsible for payment. The Network/Participating Provider must have the Covered Individual sign a statement that he or she understands these terms or the Network/Participating Provider may not bill the Covered Individual for such non-Medically Necessary services.
- From the HMO Covered Individual - Payment for any non-Covered Services only if the Network/Participating Provider advises the Covered Individual in writing before the Health Services are rendered that the specific Health Service to be provided will be non-covered and that he or she will be responsible for payment. The Network/Participating Provider must have the Covered Individual sign a statement that he or she understands these terms or the Network/Participating Provider may not bill the Covered Individual for such non-Covered Services. If the Covered Individual does not sign such a statement, the Network/Participating Provider must hold the Covered Individual harmless for the non-Covered Service(s).

A general statement that the Covered Individual shall be responsible for all charges not covered by the Covered Individual's insurance carrier or health maintenance organization is not sufficient.

The total collected for any Covered Service cannot exceed the Anthem Rate or the Network/Participating Providers charge for the Health Service. Network/Participating Providers filing Claims on the UB-04 receive a remittance voucher that provides information about how Claims submitted were processed.

What Network/Participating Providers "Write-off"

Your remittance voucher will specify the exact amounts that the Network/Participating Provider may collect from Covered Individuals. Some examples of write-offs include:

- Any amount exceeding the Anthem Rate when the Plan is primary
- Any amount for which the Covered Individual is held harmless as defined by the Covered Individual's Health Benefit Plan and the Agreement

- Services rendered by unlicensed Facility employees
- A service delegated to a Facility's employee
  These will only be covered if the following conditions are met:
  - Both the Facility and the Facility's employee are licensed to render the Health Service
  - The Health Service is performed under the Facility's direct supervision. (The supervising provider must document the supervisory role by signing the Covered Individual's record.)
  - The Health Service would be covered if it were performed by the Facility
- Health Services considered incidental to primary procedures as explained in the medical policy documentation.
- Health Services that a Facility advertises as free of charge. Charges for these Health Services should not be billed to the Anthem.

Submission of Claim/Encounter Data

Facility agrees to submit HMO/HIC Claims and encounter data to Plan on a CMS 1500, UB-04 or successor form, in a manner consistent with industry standards and Anthem policies and procedures as approved by Plan. Facility agrees to submit Traditional and PPO Claims to Plan for payment on a CMS 1500, UB-04 or successor form, in a manner consistent with industry standards and Anthem policies and procedures as approved by Anthem. Plan agrees to make best efforts to pay all Complete Claims for Covered Services submitted by Facility in accordance with the applicable state statute, exclusive of Claims that have been suspended due to the need to determine Medical Necessity, to the extent of Plan's payment liability, if any, because of issues such as coordination of benefits ("COB"), subrogation or verification of coverage. Plan agrees to make such determinations within a reasonable period of time and to cooperate with Facility, upon request, in good faith and within reason, in creating and maintaining methods and procedures to allow Anthem to efficiently identify Covered Services.

Overpayments Reimbursement

For purposes of this provider manual, overpayments reimbursement includes, but is not limited to, situations in which the Facility has been overpaid by Anthem due to an error in processing, an incorrect determination that the services were Covered Services, a determination that the Covered Individual was not eligible for services at the time services were rendered or another entity is primarily responsible for payment of the Claim. In those situations in which Facility issues a refund, such refund shall be made to Anthem within thirty (30) calendar days of Anthem's request for reimbursement or thirty (30) calendar days of when Facility knew or reasonably should have known that Anthem was not liable or had otherwise overpaid the Claim, whichever is earlier.

Avoiding Overpayments

The most common reasons for claims overpayments involve COB, duplicate payment and billing in error. To help eliminate or reduce some of these errors, we will improve our processing efficiencies and implement various systems and training improvements. When you submit Claims for secondary payments, please attach your EOB from the primary carrier.

To avoid duplicate payments, please do not submit a Claim twice for any given service. If you question the status of a Claim or wish to adjust information submitted on the original Claim, please submit a Claims Information and Adjustment Request Form (151) as soon as possible. Resubmitting the Claim with changes or corrections may create a duplicate payment.

Please be sure to accurately enter your provider National Provider Identifier ("NPI") ID number. Common errors include keying and programming the number incorrectly or receiving pre-printed Claim forms with an incorrect number. Please verify the number on pre-printed forms upon receipt.

To Return or Refund Overpayments

To return an overpayment, you can send a Refund Request form, a Claims Information and Adjustment Request Form (151), and a copy of your Facility remittance voucher. When you submit a Claims Information and Adjustment Request Form (151), please be sure to provide all of the information below:

- Facility name and number
- ID number (including the alpha prefix)
- Date(s) of service
- ***Reason for overpayment (most important field)***
- Explanation of Benefits ("EOB")

- Claim number
- Patient name
- Patient account number (optional)
- Refund amount
- Indicate retraction or refund
- Check number and amount

Send the information to the following address:

Anthem Blue Cross and Blue Shield Virginia Recovery
P.O. Box 931766
Cleveland, OH 44193

The special post office box indicated above is dedicated to provider refunds to ensure priority processing. This special mailing arrangement also enables us to analyze causes for overpayments so that we can move toward eliminating them.

The BlueCard Program

The BlueCard Program links Network/Participating Providers and the independent Blue Cross and Blue Shield Plans across the country and abroad with a single electronic network for professional, outpatient and inpatient Claims processing and reimbursement. The program allows Network Blue Cross and Blue Shield providers in every state to submit Claims for out-of-state Covered Individuals to their local Blue Cross and Blue Shield Plan, eliminating the need to track receivables from multiple Blue Cross and Blue Shield Plans. As a Network/Participating Provider you are required to accept the determination of the out-of -state Plan as communicated on your Anthem Blue Cross and Blue Shield Facility provider remittance voucher. The Covered Individual is only responsible for the amount(s) in the patient payment column of the remittance voucher.

Through the BlueCard Program, you must submit Claims for Blue Cross and Blue Shield Covered Individuals from other states directly to Anthem Blue Cross and Blue Shield in Virginia.

What are the advantages of participating in the BlueCard Program?

The BlueCard Program allows Anthem to be your focal point for all Blue Cross and Blue Shield Claims submissions, payments, adjustments, services and inquiries. It also provides you with easy access to membership and coverage information on out-of-area Covered Individuals. Call 1-800-676-BLUE for BlueCard membership and coverage line, which links you to the Covered Individual's local plan. By calling this line, you can receive eligibility, benefits and admission review. Plus, the BlueCard Program's simple billing process allows for quicker payments for your services rendered to out-of-area Covered Individuals.

What services and products are covered under the BlueCard Program?

The BlueCard Program applies to all inpatient, outpatient and professional services.

The BlueCard Program does not apply to:

- dental
- prescription drugs
- non-prefix Claims
- FEP

How do I identify BlueCard Covered Individuals?

When out-of-area Blue Cross and Blue Shield Covered Individuals arrive at your Facility, be sure to ask them for their identification ("ID") card. The main identifiers for BlueCard Covered Individuals are the alpha prefix, an empty suitcase and, for eligible PPO Covered Individuals, a "PPO in a suitcase" logo, or for eligible POS Covered Individuals, a "POS" logo on the ID card.

Alpha Prefix

The three-letter alpha prefix of the Covered Individual's ID number is the key element used to identify and correctly route out-of-area Claims. It identifies the Covered Individual's Plan or national account to which the Covered individual belongs. In conjunction with the alpha prefix, an empty suitcase is being added to all Covered Individual's cards

whose Claims are delivered through BlueCard while traveling out-of-area. This will further assist you in determining how Covered Individual's Claims are processed. This new identifier does not replace the use of the BlueCard PPO identifier currently present on BlueCard PPO cards.

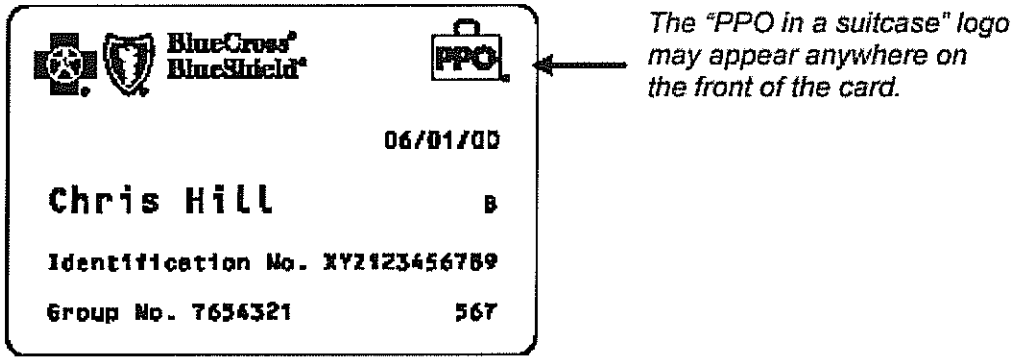
Some ID cards may not have an alpha prefix. This indicates that the Claims are handled outside the BlueCard Program. If the ID number does not have a prefix, send the claim to the Covered Individual's Blue Cross and Blue Shield Plan.

The address is on the back of the Covered Individual's ID card.

ID cards with three-character alpha prefixes beginning with "ZZ" indicate international Blue Cross and Blue Shield Covered Individuals.

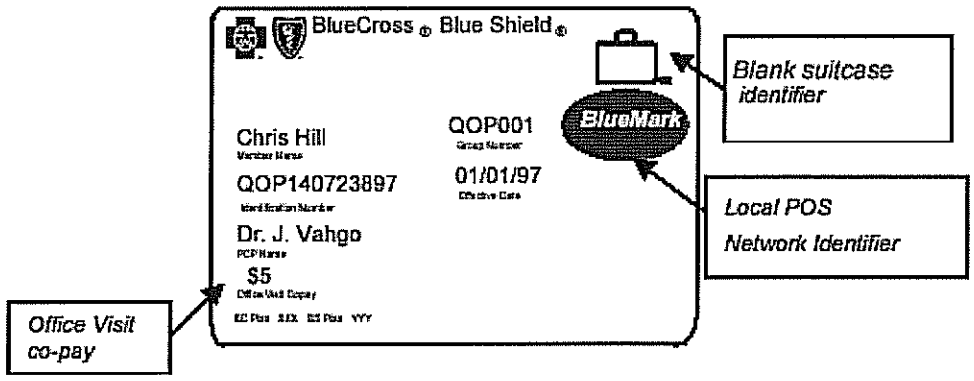
BlueCard PPO Covered Individuals

You will immediately recognize Blue Cross and Blue Shield PPO Covered individuals by the special "PPO in a suitcase" logo on the ID card. BlueCard PPO Covered Individuals are Blue Cross and Blue Shield Covered Individuals whose PPO benefits are delivered through the BlueCard Program.



BlueCard POS (Point of Service) Covered Individuals

You will immediately recognize BlueCard POS Covered Individuals by the special POS logo found in the upper right hand corner of the ID card. BlueCard POS Covered Individuals are Blue Cross and Blue Shield Covered Individuals whose POS benefits are delivered through the BlueCard program. Utilization Management is performed by the Health Plan, when the card indicates POS below the suitcase. If the Health Plan POS Network is not mentioned, the Covered Individual should be treated as standard BlueCard. As new POS groups are added, an announcement will be placed in the Professional Forum.



Make a Copy of the BlueCard Covered Individual's ID Card

It is very important to capture all ID card data at the time of service. This is critical for verifying eligibility and coverage. We suggest that you make copies of the front and back of the ID card and pass this key information on to your billing staff. Do not make up alpha prefixes. Be sure to submit all alpha numeric characters on the Covered Individual's ID number.

When and How do I Submit BlueCard Program Claims?

You should submit your BlueCard claims to Anthem Blue Cross and Blue Shield of Virginia.

Be sure to include the Covered Individual's alpha prefix and the Covered Individual's complete ID number when you submit the Claim. Do not make up alpha prefixes. A Covered Individual's ID number is the three character alpha prefix followed by four (4) to fourteen (14) alpha numeric characters. Incorrect or missing alpha prefixes and Covered Individual ID numbers delay Claims processing.

The Claims submission process for international Blue Cross and Blue Shield Covered Individuals (Blue Cross and Blue Shield of Western Europe, for example) is the same as for domestic Blue Cross and Blue Shield Covered Individuals.

Some ID cards with an alpha prefix may not display the suitcase logo. These Claims are not eligible for BlueCard. These Claims should be forwarded to Anthem Blue Cross and Blue Shield of Virginia. We will electronically send your Claim to the Covered Individual's home plan for processing. You will be able to obtain Claim status and receive payment information on your remittance voucher. Payment in most instances will be made to you as a Network/Participating Provider.

Some ID cards may not have an alpha prefix. This indicates that the Claims are handled outside the BlueCard program. If the ID number does not have a prefix, send the Claim to the Covered Individual's Blue Cross and Blue Shield Plan listed on covered individuals ID card.

Bordering Counties (Contiguous Areas)

If your Facility is located in an area where two Blue Cross and Blue Shield Plans share a county (e.g., Washington, D.C., North Carolina, Tennessee, etc.) the following scenarios explain filing Claims under these circumstances.

Scenario 1: If you have a Network agreement with the Blue Cross and Blue Shield Plan that insures the Covered Individual, submit the Claim directly to that Plan.

Example: A Facility in Northern Virginia has a Network agreement with both Anthem Blue Cross and Blue Shield and the Washington, D.C./Maryland plan (CareFirst BlueCross BlueShield). A Covered Individual insured by CareFirst BlueCross BlueShield visits this Facility. The Facility should file the Claim to CareFirst BlueCross BlueShield. If an Anthem Blue Cross and Blue Shield Covered Individual visits this Facility, the Facility should file the Claim to Anthem Blue Cross and Blue Shield. If the Covered Individual is not insured by CareFirst Blue Cross Blue Shield or Anthem Blue Cross and Blue Shield, the Claim should be filed to CareFirst Blue Cross Blue Shield.

Scenario 2: If a Facility has a Network agreement with two Blue Cross Blue Shield plans and a Covered Individual insured by a Blue Cross and Blue Shield Plan other than the two with which the Facility has a Network agreement visits the Facility, the Facility should file the Claim to the Blue Cross and Blue Shield Plan that services the physical location of the Facility.

Example: A Covered Individual insured by BlueCross BlueShield of Illinois visits a Facility in Virginia. The Facility is in Virginia, but near the Virginia/North Carolina border, so the Facility has a Network agreement with both Virginia and North Carolina. The Facility should file the Claim to Anthem Blue Cross and Blue Shield since all Facilities on the Virginia side of the Virginia/North Carolina border are in Anthem Blue Cross and Blue Shield's service area.

Scenario 3: If you do not have a Network agreement with the Blue Cross and Blue Shield Plan that insures the Covered Individual, submit the Claim directly to your local Plan.

Example: A Facility in Northern Virginia has a Network agreement with Anthem Blue Cross and Blue Shield only. A Covered Individual insured by the Washington, D.C./Maryland plan (CareFirst BlueCross BlueShield) visits this Facility. The Facility should file the Claim to Anthem Blue Cross and Blue Shield.

Utilization Review

You should remind out-of-area Covered Individuals except for BlueCard POS Covered Individuals that they are responsible for obtaining - admission review / health services review for services from their Blue Cross and Blue Shield Plan. You may also choose to contact the Covered Individual's Plan on behalf of the Covered Individual. If you choose to do so, refer to the back of the Covered Individual's ID card for the correct phone number.

Medical Records

When Anthem requests medical information, a timely return of those records will expedite Claims adjudication. A turnaround time of ten (10) days from the request receipt is recommended.

When do I call Anthem vs. the Covered Individual's "home" Plan?

Call Anthem Member Services for post service needs:

- Claim status
- adjustments (additional payment and retractions)
- late bills/rebills
- requests for additional information

Call the Covered Individual's home Plan at 1-800-676-Blue for pre-service needs:

- benefits
- eligibility

How do I handle Covered Individual questions regarding Claims status or payment?

Tell Covered Individuals to contact their Blue Cross and Blue Shield Plan. Refer them to the front or back of their ID card for a customer service number.

If the Covered Individual's Plan requests you to send it another copy of the Covered Individual's Claim, please report this to Anthem.

Submission of Claims under the Federal Employee Health Benefit Program ("FEHBP")

All Claims under the Federal Employee Health Benefit Program ("FEHBP") must be submitted to Plan for payment within one (1) year from the date the Health Services are rendered. Network/Participating Provider agrees 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 payor, the one (1) year period will not begin to run until Nework/Participating Provider receives notification of primary payor's responsibility. Plan is not obligated to pay Claims received after this one (1) year period. Except where Covered Individual did not provide Plan ID, Network/Participating Provider 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.

Federal Employee Program (FEP) for non-HMO FEP Covered Individuals

For the Federal Employees Program administered by Blue Cross and Blue Shield for non-HMO FEP Covered Individuals, where you submit Claims depends on where the services are rendered, not where the patient lives. If Blue Cross and Blue Shield receives Claims for FEP (non-HMO) Covered Individuals for services rendered outside of the Blue Cross and Blue Shield service area, the Claims will not be processed and will be returned to the Facility.

FEHBP Claims Submission in Northern Virginia and Washington, D.C.	
If services for FEHBP Covered Individuals are rendered:	**then, submit the Claim to:**
West of Route 123:	Anthem Blue Cross and Blue Shield Federal Employee Program (FEP)
East of Route 123 (including addresses on Route 123) and all of the cities of Alexandria and Fairfax, the Town of Vienna, and Arlington County	CareFirst BlueCross BlueShield

Erroneous or duplicate Claim payments under the Federal Employee Health Benefit Program ("FEHBP")

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 within 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.

HMO Away From Home Care

Urgent care and emergency services outside the service area are provided to help Covered Individuals if they are injured or become ill while temporarily away from the service area. Benefits for these Health Services are limited to care which is required immediately and unexpectedly. Elective care and care required as a result of circumstances which could reasonably have been determined prior to leaving the service area are not covered. Benefits for maternity care do not cover normal term delivery outside the service area, but do include earlier complications of pregnancy or unexpected delivery occurring outside the service area.

Benefits for continuing or follow-up treatment must be pre-arranged by the Covered Individual's primary care physician and provided in the service area and are subject to all provisions of the Covered Individual's Health Benefit Plan.

If an emergency or urgent situation occurs when the Covered Individual is temporarily outside the service area, the Covered Individual:

- should obtain care at the nearest Facility;
- or a representative on the Covered Individual's behalf, must call the twenty-four (24) hour notification line within forty-eight (48) hours of the time of the visit to notify the Plan that Health Services were received;
- will be responsible for payment of charges at the time of their visit; and
- should obtain a copy of the complete itemized bill for filing a Claim with the Plan.

If the Covered Individual is hospitalized as a result of receiving emergency services, they or a representative on their behalf must notify the HMO within forty-eight (48) hours or the next business day after the Covered Individual begins receiving care. Failure to do so may result in denial of benefits.

Guest Membership

For Covered Individuals away from home for at least ninety (90) days for things such as extended out-of-town business, semesters at school or families living apart, HMO Plans that participate with the Blue Cross and Blue Shield Association HMO national network offer guest membership at an affiliated Blue Cross and Blue Shield Association HMO. Guest Members from other HMO service areas will receive a special HMO ID card from HealthKeepers, Inc. The ID card will be stamped "Guest Member". These providers are reimbursed on a fee-for-service basis and the guest member will not appear on a capitation report. If you see a Covered Individual in this situation, please file the claim to HealthKeepers, Inc. We will coordinate payment with the Covered Individual's home HMO plan.

Helpful Hints

Changes During Admission

There are five (5) elements that could change during an admission. The following table shows the scenarios and the date to be used:

CHANGE	EFFECTIVE DATE
Covered Individual's Insurance Coverage	Admission
Network/Participating Provider's Payment Methodology	Admission
Network/Participating Provider's Payment Rate	Admission
DRG Grouper Version	Admission
DRG Relative Weight	Admission

Coordination of Benefits

If a Covered Individual or eligible dependent is covered by more than one Health Benefit Plan, the carriers involved work together to prevent duplicate payments for any services. This cooperative effort is called Coordination of Benefits ("COB"), a provision in most Health Benefit Plans.

When it is known or there is reason to believe that other coverage exists, Claims are not paid until the other carrier's liability has been investigated. This is normally done by using a questionnaire sent to the Covered Individual. If the Covered Individual completes the questionnaire indicating that he or she is covered by additional Health Benefit Plans, the records are marked to indicate that other carrier information is required in order to complete Claim processing when the other carrier's Health Benefit Plan is primary. Some employers conduct this process once a year during their open enrollment period.

If the Plan is other than the primary payor, any further compensation to Network/Participating Provider from the Plan or the Covered Individual will be determined in accordance with the Agreement, the applicable Health Benefit Plan and any applicable Plan written policies and procedures for coordinating benefits. Such compensation from Plan as a secondary payer plus the amounts owed by all other sources, including the Covered Individual, shall add up to one hundred percent (100%) of the Anthem Rate.

Notwithstanding the foregoing, in no event shall Plan or the Covered Individual be required to pay more than they would have paid had the Plan been the primary payor. Network/Participating Providers will not collect any amount from the Covered Individual if such amount, when added to the amounts collected from the primary and secondary payors, would cause total reimbursement to Network/Participating Provider for the Covered Service to exceed the amount allowed for the Covered Service under the Agreement. Further, this provision shall not be construed to require Network/Participating Provider to waive Cost Share in contravention of any Medicare rule or regulation, nor shall this provision be construed to supersede any other Medicare rule or regulation. If, under this Section, Network/Participating Provider is permitted to seek payment from other sources by reason of the existence of other group coverage in addition to Plan's Health Benefit Plan, then Network/Participating Provider may seek payment from the other sources on a basis other than the Anthem Rate.

To the extent permitted by law, Plan may, under third party liability, third party recovery, or similar provisions of Health Benefit Plans, service agreements, certificates or other documents setting forth terms and conditions of health coverage, become entitled to refunds of benefit amounts paid by Plan. However, the right of Plan to such a refund will not, in any case, affect or increase the maximum compensation to which Network/Participating Provider is entitled under the Agreement for any services that are, or in the absence of Plan's right to such refund would be, Covered Services.

The ***primary*** carrier is responsible for paying the full benefit amount allowed by its Health Benefit Plan. The ***secondary*** carrier considers for payment any part of the service that has not been covered by the ***primary*** carrier. When the Plan is secondary, it allows providers to retain payments from a *primary* carrier that are in excess of the Plan's allowance. This rule only applies to coordination of health insurance. It does not apply to auto insurance.

All Network/Participating Providers are required to submit Claims for all services rendered. This is the case whether another carrier is involved or if the Plan is primary or secondary.

Regardless of whether the Plan is primary or secondary, follow the Plan's Utilization Management guidelines in order to receive reimbursement from the Plan.

Determining Primary vs. Secondary Coverage for Dependents—The Birthday Rule

The description below assumes that dependents are enrolled and eligible for coverage. If an individual is not eligible for coverage, then there are no benefits available for that individual.

Under most COB provisions, dependent children are covered first by the Health Benefit Plan of the parent whose birthday falls earlier in the calendar year. If the birth dates are identical, the Health Benefit Plan that has covered the dependent longer becomes primary.

Example: Father's birthday is August 30, 1957
Mother's birthday is February 25, 1963

The mother's Health Benefit Plan is primary on child(ren) because her birth date falls first in the calendar year.

The birthday rule does not apply when an individual is the insured under one Plan and the dependent under another. In this situation, the Plan covering the Covered Individual as the policyholder is primary.

The Custodial Rules (Dependents of Divorced Parents, etc.)

If the parent with custody has not remarried, the parent with custody provides primary coverage and the parent without custody provides secondary coverage.

If the parent with custody has remarried, the parent with custody provides primary coverage, the step-parent provides secondary coverage, and the parent without custody provides tertiary coverage.

If there is a court decree that fixes financial responsibility for health care of dependent children, the decree will supersede the above rules.

If there is joint custody, refer back to "the birthday rule".

When the Plan is Primary

Please perform the following steps when the Plan is the primary insurer:

1. Submit the Claim to Anthem first.
2. Bill the other carrier (The other carrier may require you to attach a copy of the remittance voucher.)

When the Plan is primary, the Claim is processed as if no other coverage exists.

When the Plan is Secondary

When the Plan provides secondary coverage to a Covered Individual for a Covered Service under a "COB" provision in the Covered Individual's Health Benefit Plan, the Plan will pay or administer payment for the Covered Service in accordance with the COB rules set forth in the Covered Individual's Health Benefit Plan.
You will accept such payment as fulfilling the Plan's payment obligation to you under the Agreement.

You may also collect from the primary carrier, but not the Covered Individual, the amount allowed for the Covered Service by that primary carrier.

Please perform the following steps when the Plan is the secondary carrier.

1. Do not collect Cost Shares from the Covered Individual until both carriers have processed the Claim. (Between the two, the Cost Share may be covered.)
2. Bill and collect from the primary carrier first. (This includes fee-for-service procedures and primary care capitated services.)

3. Submit the Claim to Anthem and attach the primary carrier's explanation of payment. (Primary care providers file the Claim regardless of whether the service is capitated or fee-for-service.)

If You are Unsure of Who is Primary

Contact each carrier to determine who is primary or secondary.

Medicare Part A and B crossover process

Since June 2006, Anthem has participated in the Medicare Part A & B crossover process through connectivity to Medicare's national coordination of benefits contractor (COBC). Global Health Inc. (GHI) is the Medicare COBC Contractor. Our participation impacts both Part A and Part B services, and expands our capability to receive crossover Claims for all Medicare intermediaries. The need to file supplemental paper Claims after Medicare completes processing continues to be significantly reduced.

Crossover claims delivered to Anthem fourteen (14) days after Medicare approval

In the past, some Medicare intermediaries and carriers would cross over their Claims when Claims were approved, and some intermediaries waited until the fourteen (14) day Medicare payment floor expired. For consistency going forward, all EDI Primary Medicare Claims that indicated a secondary insurance handled via COBC will be crossed over once the fourteen (14) day Medicare payment floor has expired. Medicare contractors/CMS Fiscal intermediaries will continue to notify providers via an Explanation of Medicare Benefits (EOMB) form, indicating when a Claim has been filed through the crossover process.

Note: If the Medicare primary Claim was processed via paper submission, then the payment floor is thirty (30) days before the Claim will be crossed over for secondary processing and payment.

Crossover time frames may cause providers to modify accounts receivable process

With the changes implemented with GHI, Anthem does not receive Medicare Claims until the Medicare payment floor has been satisfied fourteen (14) days after the approval date. Please allow one (1) month before contacting Anthem regarding a particular Medicare crossover Claim, since most Claims are processed well within this time frame. Do not re-file these Claims electronically or via paper submissions, because this action creates duplicate Claim situations which lead to processing and payment delays.

Going forward, providers should work with their office staff, billing agencies or clearinghouses to make sure they're not converting Medicare Claims to a paper format too soon. If you need further assistance, please contact our EDI Help Desk at **800-991-7259**. Select option 2 and option 2 again. If you prefer, visit us on the Web at **anthem.com/edi** and select the "Live Chat" option.

When filing Coordination of Benefits Claims electronically for UB-04

Anthem provides a Companion Guide, to assist Facilities with the submission of electronic Claims. The Companion Guide contains complete instructions for the electronic billing of Coordination of Benefit Claims. If you would like to learn more refer to the Companion Guide (appropriate 837 section) located on our web site at www.anthem.com for complete details – just select the Virginia tab under the physicians and provider section and click on "Enter Site. " Next, select the "EDI" link and then the "Companion Guide" link. Refer to the table of contents for particular topics.

Subrogation Processes May Apply to the Plan's Self-Insured Groups

Self-insured groups are those that accept their own risk and reimburse Plans for Claims paid. Subrogation may only apply to self-insured groups. If a Covered Individual covered by a self-insured group that chooses to subrogate is injured at the fault of another individual, then the injured Covered Individual may have potential legal Claims against a third party, including (1) the individual who caused the injury, (2) the individual's carrier, and/or (3) the injured Covered Individual's automobile insurance. The process of the Plan initiating a Claim to recover payments made on Health Service Claims against the proceeds of a Covered Individual's liability Claim is called subrogation.

How Subrogation May Occur for Self-Insured Groups

When a Claim form indicates that injuries are a result of an accident, the Plan or contracted attorneys may send a letter and questionnaire to the Covered Individual to find out how the injury occurred, whether it was work-related, and whether an attorney will be hired in connection with the injury. If the first questionnaire is not returned within six (6) weeks, a second request is mailed. If no response is received within another six (6) weeks, the Covered Individual is mailed a third and final request.

If a third party liability injury is confirmed, a letter stating the Plan's right to subrogate is sent to the Covered Individual's attorney, the third party, and the third party's carrier. The Plan representative negotiates with the Covered Individual's attorney and the third party's carrier until an agreement is reached.

Comprehensive Health Planning

Network/Participating Provider shall not bill Anthem or a Covered Individual for Health Services, expanded facilities, capital operating costs or any other matter of service requiring a certificate of need approval or exemption under existing law, or similar or successor laws that may be adopted from time to time, unless said approval or exemption has been granted in writing.

Courtesy Room

Network/Participating Provider shall not bill Plan and/or Covered Individuals for any charges related to use of a Courtesy Room in the provision of Health Services to a Covered Individual. "Courtesy Room" means an area in the Facility where a professional provider is permitted by Facility to provide Health Services to Covered Individuals, which could otherwise be provided in an office setting.

Daily Supply or One Time Charge Fees/Items

Supply fees billed daily or one time, which are unidentified and unsupported by medical records or documentation are not reimbursable. Examples of daily supplies include those commonly used services and supplies provided in relatively equal quantities to all patients in similar circumstances. It also includes those inexpensive supplies and medications for which it is uneconomical to account separately.

Eligibility and Payment

A guarantee of eligibility is not a guarantee of payment.

Facility Records

Facility shall prepare and maintain all appropriate medical, financial, administrative and other records as may be needed for Covered Individuals receiving Health Services. All of Facility's records on Covered Individuals shall be maintained in accordance with prudent recordkeeping procedures and as required by any applicable federal, state or local laws, rules or regulations.

Facility Personnel Charges

Charges for Inpatient Services for Facility personnel are not separately reimbursable and the reimbursement for such is included in the room and board rate. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions, call back charges, nursing increments and respiratory services. Outpatient Services for Facility personnel are also not separately reimbursable. Reimbursement is included in the reimbursement for the procedure or observation Charge.

Instrument Trays

Charges for instrument trays for any procedure are included in the cost of the procedure and are not separately reimbursable.

Labor Care Charges

Plan will reimburse appropriately billed room and board when the patient is inpatient or appropriate labor charges when patient is outpatient.

Nursing Procedures

Plan will not separately reimburse fees associated with nursing procedures or services provided by Facility nursing staff or unlicensed facility personnel (technicians) performed during an inpatient ("IP") admission or outpatient ("OP") visit. Examples include, but are not limited, to intravenous ("IV") injections or IV fluid administration/monitoring, intramuscular ("IM") injections, subcutaneous ("SQ") injections and nasogastric tube ("NGT") insertion, catheter insertion, with the exception of OP blood administration or OP chemotherapy administration.

Other Agreements Accepted

Facility may currently maintain a separate agreement with Anthem solely for the provision and payment of home health care services, skilled nursing facility services, ambulatory surgical facility services, or other agreements that Anthem designates (hereinafter collectively "Other Agreement(s)"), said Other Agreement(s) will remain in effect and control the provision and payment of Covered Services rendered there under.

Partial Day Programs

There are three (3) types of Partial Day Programs:

- Partial Day Psychiatric Program
- Partial Day Substance Abuse
- Intensive Outpatient Substance Abuse Program

Partial Day Billing Guidelines

Partial Day/Intensive Outpatient Claims must be filed to Anthem on the UB-04

Bill Types:

- 191 Admission through discharge
- 192 First interim bill
- 193 second and all subsequent interim bills
- 194 Final Bill for interim

Revenue codes:

- 100 for partial day charges that include all ancillary charges
- 183 for therapeutic leave, should always have a zero dollar amount for the days without treatment

Remarks:
(This will indicate the authorization level of care)

- P1 for Partial Day
- P2 for Substance abuse
- P3 for IOP

Personal Care Items

Personal care items used for Covered Individual's convenience are not reimbursable. Examples include but are not limited to: breast pumps, deodorant, dry bath, dry shampoo, lotion, non-medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, toothbrush and toothpaste. Items used for the Covered Individual 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 Covered Individual. 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.

Pre-Operative Care or Holding Room Charges

Charges for a pre-operative care or holding room used prior to a procedure are included in the reimbursement for the procedure, and are not billed separately. Nursing care provided in the pre-operative care area will not be reimbursed separately. Reimbursement for the procedure includes all nursing care provided.

Preparation (Set-Up) Charges

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

Preventable Adverse Events

Acute Care General Hospitals – Preventable Adverse Events Policy

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 Health 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 Plan, to the extent reasonable, in any Plan 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 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 Plan for

payment. In no event shall the charges or days associated with the HAC be billed to either Plan or the Covered Individual.

Network/Participating Provider (excluding Acute Care General Hospitals) – PAE Policy

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 Network/Participating Provider shall neither bill, nor seek to collect from, nor accept any payment from the Health Plan **or** the Covered Individual for such events. If Network/Participating Provider 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, Network/Participating Provider shall cooperate with Plan, to the extent reasonable, in any Plan 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, Network/Participating Provider 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.
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.

Private Room Charges and Rate Changes

The Facility shall provide Covered Individuals with a Semi-private Room, when available, unless other accommodations are requested or unless a private room is prior-approved by an Affiliate or Plan. The Facility shall allow a Covered Individual occupying a private room such credit against the charge therefore as shall be provided in the Agreement. The Facility shall notify Anthem in advance of any changes to its room rates. For the purposes of this paragraph a "Semi-private Room" shall mean a room containing two (2) or more beds.

Facilities should submit room rate changes on a yearly basis in order to receive the correct reimbursement for Covered Services. Your changes should be submitted in writing at least thirty (30) days prior to the effective date**. If you bill Anthem using more than one NPI we need to know if the changes apply to each number. Include the following information with your room rate changes:

- Effective date
- Facility Name
- All applicable numbers
- New Rates

Send your written requests to:

Anthem Blue cross and Blue Shield
Wanda McGee – Maildrop VA4004-RR04
2221 Edward Holland Drive
Richmond, Va 23230

Fax your request to:

Anthem Blue Cross and Blue Shield
Attention Wanda McGee
Fax Number 804-354-2383

E-Mail request to:

Wanda McGee@Anthem.com

** Requests for room rate changes received after the effective date will be made effective the date the request is received.

Special Procedure Room Charge

Special procedure room Charges are included in the reimbursement for the 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 are included in the reimbursement for the procedure and also are 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)

Facility agrees to accept, consistent with Facility policies, the results of qualified and timely laboratory and radiological tests or other procedures which may have been performed on a Covered Individual prior to Facility rendering services to Covered Individuals. Facility will not require that duplicate tests or procedures be performed or charged, unless such tests or procedures are ordered by a provider.

Diagnostic services are defined by the following Revenue and/or CPT Codes:

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, with CPT codes, 93015, 93307, 93308, 93320, 93501, 93503, 93505, 93510, 93526, 93541, 93542, 93543, 93544-93552, 93561 or 93562
53X – Osteopathic services
61X – MRI
62X – Medical/surgical supplies, incident to radiology or other services
73X – EKG/ECG
74X – EEG
92X – Other diagnostic services

Undocumented or Unsupported Charges

Per Anthem policy, Anthem 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 such as batteries, covers, film, anti-fogger solution, and tapes are not separately reimbursable.

Coverage Guidelines

Utilization Management Program

This document constitutes the utilization review plan required by Section 32.1-137.10 of the Code of Virginia for all Anthem companies that conduct utilization review as defined in Section 32.1-137.7 of the Code of Virginia. For the purposes of this Utilization Management Program, the Affiliates are listed at www.anthem.com.

This document is intended for the express purpose of providing a record that describes the prospective and concurrent Utilization Management activities of the Plan (and their designees) with providers of health care. Network/Participating Providers agree to participate in this Program as it may be amended, modified or updated from time to time. By participating in this Program, the Network/Participating Provider agrees to strictly adhere to and comply with all of the terms, requirements, and guidelines of this document

I. Introduction

Because the escalation of health care costs has become a national and local issue, the Plan considers effective medical management an essential process, strategically directed at maintaining quality health care while curtailing unnecessary costs associated with inappropriate consumption of health care resources.

The Utilization Management Program affords the following opportunities to Facilities, Physicians and Covered Individuals:

1. It limits the potential for and/or the number of retroactive denials.
2. If adhered to, significantly reduces the need for requesting additional medical information to evaluate and justify health care resource coverage.
3. It promotes compliance with policy benefit provisions resulting in sound health care delivery with appropriate compensation for services rendered.

Contact Information:

Website – http://www.anthem.com

Telephone Numbers:

1-800-533-1120 Anthem Blue Cross and Blue Shield Provider Data Touch Interactive Voice Response System

Group Plan Service Operations

Pharmacy Management

Behavioral Health (can also be reached at 1-800-991-6045)

Medical Management

1-800-321-8318 Anthem Blue Cross and Blue Shield Individual or Government business

1-800-421-1883 HealthKeepers, Inc. and Anthem HealthKeepers Plus

1-757-431-5270 Anthem HealthKeepers Plus

II. General Information

1. The following terms, as used in this document, shall have the meanings ascribed to them in the Plan Facility Agreements:
   a. Medically Necessary
   b. Covered Person – will be referred to as "Covered Individual"
   c. Contract/Evidence of Coverage – will be referred to as "Health Benefit Plan"
   d. Inpatient
   e. Outpatient
2. Utilization Management Program ("UMP") shall mean Plan or its designees who perform the utilization management services described in this document.
3. Health Services Review shall mean the authorization of services as Medically Necessary and a contractually covered benefit.
4. Admission Review shall mean the review of Inpatient Services as Medically Necessary and a Covered Service under the Health Benefit Plan.
5. Emergency or Emergency Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with an average knowledge of health and medicine, could reasonable expect the absence of immediate medical attention to result in: (1) serious jeopardy to the health of the individual, or, in the case of a pregnant woman, the health of the woman or her unborn child; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part..
6. This document applies to Medical Necessity review as described. Covered Individuals who are customers of national Blue Cross Blue Shield accounts are subject to the medical policy and medical review requirements of those national account Plans. Admission Reviews, concurrent reviews, outpatient reviews and retrospective audits are for the purpose of confirming Medical Necessity and do not eliminate the need for verification of a Covered Individual's Health Benefit Plan coverage including other exclusions such as, dental, investigative, and experimental procedures. All other provisions of any Health Benefit Plan, including but not limited to the other coverage exclusions, limitations on days, and appropriate waiting periods, shall continue to be enforced and are not subject to this program General patient eligibility and coverage information and patient-specific Health Services Review requirements may be obtained by calling the Provider Inquiry Unit

7. Under this Utilization Management Program, audit activity may include a review of any or all of the following: Medical Necessity, charges, diagnosis and other coding, and documentation of services rendered.

8. Any references made in this document to Plan will include any review agents engaged by Plan to perform Medical Necessity and audit reviews of services rendered by the Facility and its staff. Therefore, the same cooperation afforded Plan will also be expected for any of its agents.

9. A service review for Medically Necessity may be obtained by calling the UMP which is open Monday through Friday during normal business hours with the exception of Health Plan designated holidays. See contact information in Article I.

10. In the event that services are determined to be not Medically Necessary, no Facility services will be reimbursed for the denied services or days of care. Questions regarding payment for services should be directed to the Provider Inquiry Unit. The Covered Individual is not responsible for fees unless, before such services are rendered, the Covered Individual signs an acknowledgment and consent form as required by the Agreement. This does not apply to other insurance coverage the Covered Individual may have with another third-party payer.

11. The UMP shall have reasonable access to medical records of Covered Persons as needed for the purposes of utilization management or quality improvement activities. Photocopies of Facility records or review of such records requested by the UMP shall be supplied without charge by the Facility.

12. To ensure the Covered Individual receives the highest level of benefits, Network/Participating Providers should refer Covered Individuals to Network physicians and hospitals. The UMP may authorize Medically Necessary covered specialized services that are not available in the Network and that can only be rendered by a non-Network physician or hospital (inpatient or outpatient) provided that these services are approved in advance through the UMP. However, any service available in the Network must be rendered by a Network/Participating Provider, with the exception of emergency services as defined below, which will be authorized at the in-Network benefit level wherever they are rendered. The reconsideration and appeal process described in Article XII is available.

13. The Plan ensures the confidentiality of Covered Individual-specific medical records and information in accordance with applicable state and federal laws and regulations. A breach of confidentiality by employees of these companies may result in disciplinary action up to and including termination of employment. Information requested during the Admission Review process is limited to Covered Individual-specific information necessary for proper adjudication of the Claim and used solely for the purposes of medical management activities. It is shared only with those individuals and entities that have authority to receive such information. All medical record information submitted to Plan will be maintained for a period of five (5) years.

14. An "Observation Bed" is defined as a bed within a hospital, but outside of the recovery room setting, which is used for skilled observation and/or outpatient acute care treatment of a Covered Individual experiencing complications following an outpatient surgical procedure which is occupied by such Covered Individual for more than two (2) hours and less than twenty-four (24) hours. *See Observation Bed Coverage Policy.*

III. General Requirements of the Facility:

1. The Facility shall fully and diligently cooperate with and abide by all elements of the Utilization Management Program, including but not limited to the following components of the Program: Admission Review, telephonic and/or onsite Concurrent review, and Outpatient review. The Facility agrees to provide medical information in a timely manner to the Utilization Management Program for the purpose of determining the Medical Necessity of the Covered Individual's care.

2. The Facility must have internal, active Utilization Review and Quality Assurance Programs inclusive of discharge planning, meeting all standards of compliance through The Joint Commission ("TJC").

3. Any services ordered and not documented as having been performed in the medical record or in ancillary departmental records will not be reimbursed. Documentation should reflect who rendered what service, why, when and to whom. See Documentation Guidelines for Medical/Surgical Record Documentation

Standards for Inpatient and Outpatient Hospital Records and Medical Record Documentation Standards for Ambulatory Surgery and; Behavioral Health Documentation Guidelines.

4. Under this Utilization Management Program, the Facility agrees to allow on-site reviews, concurrent and/or retrospective, by the Utilization Management Program review staff to examine the medical records and/or itemized bills related to Claims under the Program. The UMP reserves the right to make benefit determinations based on these reviews and retract any reimbursement made based on falsified, misleading or incomplete information. The method of review and selection of cases will be determined by the UMP.

5. If the Facility participates in the partial day and/or intensive outpatient programs, it is the responsibility of the Facility to adhere to the standards and guidelines outlined in the Plan's Regulations for Partial Hospital Programs or Substance Abuse Intensive Outpatient Programs.

IV. Facility Rights and Responsibilities for Admission Review

1. While the Facility may complete the Admission Review process as a courtesy to the attending physician, it is the responsibility of the attending physician to ensure that the Admission Review requirements are completed.

2. In order to provide a timely response, all elective Admission Review requests (except routine maternity admissions) should be made to the UMP during normal business hours at least three (3) business days in advance of the admission.

3. For emergency medical, surgical or behavioral health admissions, Admission Review must be requested by the end of the first business day following the admission or within forty-eight (48) hours of the admission, whichever is later.

4. Direct inpatient transfers made from one Facility to another will require Admission Review. Procedures are the same as for any Admission Review request.

5. The Facility should ensure the Admission Review requirements (including continued stay reviews) have been performed for all Inpatient Services for Covered Individuals. Failure to obtain an Admission Review for an admission may result in partial or full denial of coverage if, in retrospect, the services are determined not to be Medically Necessary.

6. The following information is required for the UMP to complete an initial review:
   a. Covered Individual ID number and Covered Individual name,
   b. Physician's name, address and phone number,
   c. Facility name and address,
   d. Admission date and anticipated length of stay, frequency and duration of previous Outpatient Service(s) and medical information pertinent to determining Medical Necessity of planned care. This includes presenting clinical symptoms, relevant medical history and previous treatment, lab/radiological results, treatment plan orders, patient response to treatment and discharge needs.

V. Facility Rights & Responsibilities for Concurrent Review & Discharge Planning

1. The Facility is responsible for requesting and obtaining an extension of the original approved duration of Inpatient Services if needed. The Facility agrees to supply medical information in a timely manner to the UMP for the purpose of determining the Medical Necessity of the Covered Individual's continued care received at the Facility. This process may be coordinated with the Facility. Approval of benefits for continued hospitalization is subject to care continuing to be Medically Necessary. Failure to obtain prior review of all inpatient days may result in partial or full denial of coverage if, in retrospect, the services are determined not to be Medically Necessary. For Facilities with per Confinement or case rate reimbursement, the frequency of clinical information submission for extensions will be determined by the Plan. The Facility will be responsible for providing a discharge date within one (1) business day of discharge.

2. The following information is needed for the UMP to complete a concurrent review:

a. Covered Individual ID number or Covered Individual name,
b. Current medical status of the Covered Individual including any lab/radiological results, current clinical symptoms, treatment plan and patient response to the treatment, discharge plans and progress toward implementation of those plans and anticipated length of stay.

3. Discharge Planning is an integral part of the admission and concurrent review programs. The focus is to assess Covered Individual's care needs during and after hospitalization in order to affect an appropriate and timely discharge; and to promote appropriate alternative settings of care such as the home, skilled nursing facility or outpatient department. It is the responsibility of the Facility to plan, coordinate and arrange all discharge activities to transition the Covered Individual to home or another Facility. The Facility will make all arrangements for discharge of Covered Individuals working with the UMP nurse reviewers to obtain appropriate review and verification of benefits.

VI. Facility Rights and Responsibilities for On-Site Concurrent Review

The program applies to select Facilities which the Plan designates as participating in the program and is designed to simplify the administration of concurrent review under the Utilization Management Program. Under this Utilization Management Program, the Facility agrees to allow onsite reviews, concurrent and/or retrospective.

1. The designated nurse reviewer who is stationed at the Facility, will be oriented to the Network Facility prior to beginning the program. This orientation will be conducted by the Utilization Review department within the Facility.

2. Upon mutual agreement, the nurse reviewer will follow the procedures for on-site reviewers of third party payers established by the Facility. The Facility requirements for in-hospital visits by nurse reviewers will be followed if on-site review is performed.

3. The nurse reviewer will follow established participating Facility policy when communicating directly with hospitalized Covered Individuals. Any communication will be coordinated through the Utilization Review department of the Facility. If allowed by Facility policy, the designated nurse reviewer will request someone from the Utilization Review staff or nursing staff to accompany him/her when visiting a Covered Individual.

4. The Admission Review process should be initiated through the UMP which will authorize an initial length of stay, if Medically Necessary. The provider of the service is notified of any adverse decision both verbally and in writing. Once an admission is authorized, requests for continued care will be reviewed for Medical Necessity.

5. If the nurse reviewer finds that the Covered Individual's stay cannot be certified based on review criteria, the nurse reviewer will contact the attending physician to obtain any additional information not contained in the medical record and to offer a peer to peer review with a UMP Physician Consultant.

VII. Facility Rights & Responsibilities for Medical/Surgical Outpatient Health Services Review

Some Health Benefit Plans require a Health Services Review of medical and surgical services received in the outpatient setting. While the Facility may complete a Health Services Review of Outpatient Services as a courtesy to the ordering physician, it is the responsibility of the ordering physician to ensure that the Health Services Review requirements are completed prior to services being rendered.

1. During the Health Services Review process, the UMP reviewer will need information regarding the Covered Individual's diagnosis, medical history and medical information pertinent to establish the Medical Necessity of planned care.

2. The intended frequency and duration of services along with a detailed treatment plan is required to establish an authorized period of time.

3. Once the medical information is received, the UMP reviewer will determine if the proposed services meet Medical Necessity guidelines and, therefore, can be authorized for reimbursement.

VIII. Facility Rights & Responsibilities for Behavioral Health Care Outpatient Services Review

Some Health Benefit Plans require Health Services Review for outpatient psychiatric therapeutic procedures (CPT 90801-90899) and appropriate E&M codes. Coverage for behavioral Outpatient Services is authorized when the Covered Individual's condition or symptoms and the appropriateness of treatment are determined to be in accordance with the UMP's Behavioral Health Medical Necessity Criteria. Care may be authorized by a Behavioral Healthcare's case manager, Behavioral Healthcare's Medical or Clinical Directors or a Psychiatric Consultant representing the UMP.

1. The ordering physician should preauthorize any non-emergent behavioral Outpatient Services. Health Services Reviews can be obtained during normal UMP business hours.

2. Behavioral Outpatient Services Health Services Review requests will not be reviewed retrospectively for more than sixty (60) days after the service is rendered, except in cases of emergency services. If a Health Services Review is not obtained within sixty (60) days after a non-emergent behavioral Outpatient Service is rendered, then, notwithstanding any provision to the contrary contained herein or in any Facility Agreement, Plan and Covered individual are not responsible for making any payment to the Network/Participating Provider.

3. The initial Health Services Review will cover a specified number of outpatient sessions. Any additional services must be pre-authorized and a treatment plan must be sent to the UMP's Behavioral Healthcare prior to services being rendered.

IX. Facility Rights & Responsibilities for Audit Activities

Under this UMP, the Facility agrees to allow on-site reviews by the UMP review staff to examine the medical records, utilization review sheets and/or itemized bills related to Claims under the Program. The UMP reserves the right to make benefit determinations based on these reviews and retract any reimbursement made based on false, misleading or incomplete information. The method of review and selection of cases will be determined by the UMP.

Periodically the UMP will perform retrospective audits of cases receiving Inpatient or Outpatient Services. While the focus of each audit differs, the combined purposes of these audits are to confirm documented Medical Necessity of care received, relevance of pre-procedure diagnostic testing, validation of the appropriate setting, quality of care and accuracy in coding and billing for services received. These reviews are conducted on Inpatient Services or Outpatient Services (retrospective audits); outpatient surgical services received in ambulatory surgery or free standing ambulatory surgery centers (ambulatory surgery audits); or provider bills (bill audits).

General Audit Guidelines

Prior to a review, the UMP provides the Facility with a list of the cases it wishes to review. The Facility will have these case records with itemized bills and UR worksheets available when the UMP reviewer arrives. Occasionally, a single request for a bill audit will be received. Medical documentation would then be requested for a review at the UMP location.

At the end of each review, the UMP reviewer will discuss his/her findings with designated Facility representatives. A reconciliation of findings will be made at the completion of the audit.

X. Utilization Management Program Responsibilities

1. In making Medical Necessity and other coverage determinations, Plan may give consideration, (to the extent that, and for as long as, Plan deems appropriate) to nationally recognized, consensus-based and/or published medical literature and guidelines or to criteria that are based on these (or to any portion thereof). Examples of such guidelines and/or literature that may be utilized or considered, in whole or in part, include, without limitation, Milliman Care Guidelines□. Guidelines and/or literature (or any portion thereof) developed by other national or specialty organizations may also be utilized and/or given consideration (to the extent that, and for as long as, Plan deems appropriate). Information about any guidelines and/or literature currently being used by Plan can be obtained by calling the UMP.

* Milliman Care Guidelines™ are a set of optimal clinical practice benchmarks for treating uncomplicated patients with common conditions. To obtain information about Milliman, Inc. or to obtain a copy of the Guidelines, visit its web site at www.mnr.com or call 1- 888-464-4746. Due to licensing restrictions, the UMP is unable to release entire volumes of the criteria. Guidelines for an individual diagnosis are available upon request if a question should arise during the authorization process. Theses may be obtained by contacting the UMP.

2. Behavioral Health uses mental health and substance abuse Medical Necessity criteria for the purpose of determining benefit coverage and assisting behavioral health care professionals in understanding the basis of our level of care and continuation of care decisions. The criteria are primarily symptom and behavior based, and were originally developed "in-house" by our staff of behavioral health professionals with input from behavioral healthcare practitioners throughout Virginia, including practitioners at academic institutions.

3. The latest version of the Behavioral HealthCare Medical Necessity Criteria is made available to providers and Covered Individuals at their request, and is available at www.anthem.com.

4. All utilization review standards and criteria used by the UMP are objective, clinically valid and compatible with established principles of health care. They are also sufficiently flexible to allow deviations from norms when justified on a case-by-case basis.

5. The UMP arranges the services of physician consultants who are board-certified specialists in all major specialty categories of health care on an "as needed" basis in conducting utilization review.

6. Review staff includes licensed Registered Nurses who conduct the first level review under the direction of the Medical Director or Clinical Director for Behavioral Health Care. The Medical Director and Physician staff has current unrestricted licensure to practice medicine. In addition, the Physician staff should have unencumbered DEA licenses if in active practice, evidence of board certification and malpractice coverage.

7. In addition to licensed Registered Nurses, Behavioral Health Care employs licensed clinical social workers and licensed professional counselors. Physician consultants are available during business hours for discussion of cases.

8. All Medical Necessity adverse decisions are made in the first instance by a Medical Director, Clinical Director or Physician Consultant. The UMP will make a good faith attempt to obtain information from the provider prior to rendering an adverse decision. If a Health Services Review is questioned on the basis of Medical Necessity, at any time before the UMP renders a decision, the attending physician is entitled to review the issue of Medical Necessity with a physician consultant or peer of the treating health care provider who represents the UMP.

9. If the UMP approves the admission as Medically Necessary, a length of stay will be authorized. Instructions on the method for concurrent review - whether onsite or telephonic - will be provided when the original length of stay is authorized. Most often, Admission Review determinations are made at the time of the initial contact. Complex cases may require further review.

10. The Facility is responsible for verifying whether or not discharge is occurring on schedule and supplying medical information pertinent to the need for continued inpatient status.

11. In the event that Medical Necessity cannot be established, the appeals process described in Article XII is available.

XI. Utilization Management Program Decisions

1. All Medical Necessity adverse decisions are made in the first instance by a Medical Director, Clinical Director or Physician Consultant. As used herein, an "adverse decision" means a decision by the UMP that a Health Service rendered or proposed to be rendered was or is not Medically Necessary. The UMP will make a good faith attempt to obtain information from the provider prior to rendering an adverse

decision. If a Health Services Review is questioned on the basis of Medical Necessity, at any time before the UMP renders a decision, the attending physician is entitled to review the issue of Medical Necessity with a physician consultant or peer of the treating health care provider who represents the UMP.

2. The UMP will orally communicate any utilization review decision to the treating provider no later than two (2) business days after receipt by the UMP of all information necessary to complete the review; for urgent/concurrent care, this is communicated within one (1) calendar day of the notification request. In the case of an adverse decision, the UMP will notify the treating provider in writing within two (2) business days of the decision, and the notification will include instructions on how the provider, on behalf of the Covered Individual, may seek a reconsideration of the adverse decision by telephone, including the name, address, and telephone number of a contact at the UMP.

XII. Appeals of Medical Necessity Decisions

1. The Facility, on behalf of the Covered Individual shall have the right to request reconsideration of any adverse decision. The Facility must submit reconsideration requests by telephone to the contact information listed in Section I. The decision on reconsideration will be made by a Medical Director, Clinical Director or Physician Consultant to the UMP. The Facility shall be notified of the decision on reconsideration in writing within ten (10) business days of the receipt of the request for reconsideration with copies to the Covered Individual. If the decision on reconsideration is adverse, then the decision will include the criteria used and the clinical reason for the adverse decision, the alternate length of treatment or the alternate treatment setting or settings, if any, that the UMP deems to be appropriate, and notice of the opportunity for an appeal of the adverse decision on reconsideration as described in paragraph 2 below.

2. If a request for reconsideration is made and the decision on reconsideration is adverse, then the Facility or the Covered Individual may appeal this final adverse decision. The appeal must be requested within sixty (60) days of the date that the adverse decision was made. Federal and State group contracts have specific requirements regarding timeframes for appeals to be considered and the mechanism for requesting an appeal (i.e. in writing). The appeal should be made in writing to the address indicated in the notification letter.

3. The Individual requesting the appeal shall have the opportunity to present additional evidence for consideration on appeal. Before rendering an adverse decision on appeal, the UMP shall review any pertinent medical records of the Covered Individual's ordering physician or of the Facility in which the Covered Individual receives Health Services that the appellant furnishes to the UMP. If the UMP has proposed alternative Health Services, then in the appeal the UMP shall give due consideration to the availability or nonavailability of such alternative Health Services.

4. Except in the case of expedited appeals described below, any case on appeal shall be reviewed and decided by a physician who (i) is a peer of the ordering physician, that is to say, a physician who holds a nonrestricted license from Virginia or any other state in the same or a similar specialty as typically manages the medical condition, procedure or treatment under review, (ii) has not participated in the adverse decision or the reconsideration thereof, and (iii) is not employed by or a director of the UMP. A written decision on appeal shall be provided to the appellant within thirty (30) business days after the UMP receives the required documentation. If the decision is adverse, it shall state the criteria used and the clinical reason for the decision.

5. Except in the case of expedited appeals described below, if the decision on appeal is adverse, then it shall include (i) a clear and understandable description of the right of the Covered Individual to appeal this final adverse decision to the Bureau of Insurance in accordance with Chapter 59 of Title 38.2 of the Code of Virginia, (ii) a description of the procedures for making such an appeal, (iii) the binding nature and effect of such an appeal including all forms prescribed by the Bureau of Insurance pursuant to Section 38.2-5901 (iv) the mailing address, telephone number and the electronic mail address of the Managed Care Ombudsman, and (v) advice that an appeal to the Bureau of Insurance may, except in the case of fraud, preclude the Covered Individual from exercising any other right or remedy relating to the adverse decision.

6. If the regular appeals process will delay the rendering of Health Services in a manner that would be detrimental to the health of the Covered Individual, then the ordering physician may appeal any adverse decision or adverse decision on reconsideration by telephone on an expedited basis. The UMP and the Facility will attempt to share the maximum information by telephone, or facsimile machine, or otherwise to resolve the expedited appeal in a satisfactory manner. The decision on an expedited appeal will be made by a physician consultant to the UMP within one (1) business day of the request. An adverse decision on an expedited appeal may also be appealed again through the regular appeal process.

7. The above-described appeals process applies to adverse decisions based on Medical Necessity only.

8. In the event that any applicable law is inconsistent with the above guidelines on appeals, then the law shall be controlling.

Observation Bed Policy

If referenced in the Facility Agreement, Covered Individuals occupying observation beds are outpatients and the Facility must bill the Plan accordingly. "Observation Bed" is a bed within a Facility, but outside of the recovery room setting, which is used for skilled observation and/or outpatient acute care treatment of a Covered Individual experiencing complications following an outpatient surgical procedure. The Plan will recognize Observation Bed services if the following situation occurs:

Observation Bed services are recognized for surgical patients experiencing complications following a surgical Outpatient Service. Observation Bed services begin after routine recovery room services have been completed. Routine recovery is defined as normal recovery time post-surgery which may vary by surgical procedure. *For example*, if the normal recovery time for a surgical procedure is twelve (12) hours and then the Covered Individual continues to experience a complication, Observation Bed services could begin at that point. An additional twenty-three (23) hours of Observation Bed services could be provided to the Covered Individual if their clinical condition did not require an inpatient admission.

- A patient stay of greater than twenty-three (23) hours of Observation Bed services will be evaluated for inpatient admission if requested. The Facility cannot substitute outpatient Observation Bed services for medically appropriate inpatient admissions and the Plan can not substitute outpatient Observation Bed services for medically appropriate Inpatient Services.

Normal Post Operative Outpatient Surgical Coverage

For outpatient surgery services without documented complications, where the Covered Person remains past the normal recovery time, no additional recovery room or Observation Bed charges will be reimbursed by the Plan. The Covered Individual should be discharged within twenty-four (24) hours of registration.

Billing:

Observation Bed services will not be recognized nor reimbursed for obstetric, psychiatric services or medical services.

Observation Bed services shall be billed under revenue code 760 (observation bed/treatment room) or 762 (observation bed) and surgical type service code.

When an inpatient admission is required following Observation Bed services, Observation Bed charges and outpatient charges will be combined with the appropriate Inpatient Services and shown on the inpatient bill.

Medical/Surgical Record Documentation Standards

Inpatient and Outpatient

Sufficient documentation in the medical record is required to enable the UMP review staff to determine Medical Necessity, quality of care, and appropriateness of treatment and to verify services performed for the purpose of determining coverage and reimbursement. All medical record documentation must be maintained for five (5) years for audit purposes.

Covered Individuals within a Facility setting must be under the medical supervision of a physician. The physician maintains responsibility for total care of the Covered Individual. Signatures and credentials are required documentation. Although members of other disciplines write notes, the physician has the responsibility of documenting the Medical Necessity for the prescribed care.

Documentation Criteria

All Facility services rendered must be appropriately documented in the Covered Individual's medical record. The medical record should be complete, legible and signed by the person providing the service. To be deemed complete, documentation of Inpatient Services must:

1. Describe the Covered Individual's clinical signs and symptoms (including specific examples) that necessitate admission including failed response to outpatient management.

2. Document an accurate and complete chronological picture of the Covered Individual's clinical course with accessibility to past and present diagnoses, and relevant health risk factors.

3. Support the intensity of the Covered Individual's evaluation and/or treatment, including provider's thought processes and the complexity of medical decision-making.

4. Document the implementation of a treatment and discharge plan specifically designed for the Covered Individual, detailing frequency and type of treatment/medication and dosage; any referrals/consultations, and Covered Individual/family education follow up needs.

5. Document Covered Individual's progress, including response to treatment, change in treatment, change in diagnosis/condition, and Covered Individual's non-compliance (if relevant).

6. Document continuous skilled observation and intervention by trained personnel consultants.

7. Document reasons for and results of x-rays, lab tests, invasive procedures, and other ancillary services.

8. Document extenuating circumstances that necessitate short periods (less than 3 hours) of absence from the Facility (i.e., court appearance, medical/surgical treatment).

9. All entries to the medical records should be dated and authenticated.

All professional provider services must adhere to the following guidelines:

1. Documentation in the medical record must verify each individual charge submitted to the Plan.
2. Documentation must specify date of service, time of service, type of service rendered, and the name and title of the health care professional who rendered the service. "Summary" notes, regardless of time periods summarized, will not be acceptable as verification of individual therapies or services provided.
3. The Coded Service Identifier(s) or successor codes reported on the health insurance claim form or billing statement should reflect the documentation in the medical record.

Discharge planning should begin at the time of admission. The initial assessment and other intervention should be documented in the medical record.

Ambulatory Surgery Record Documentation Standards

Ambulatory Healthcare Standards have been established by The Joint Commission ("TJC") for all Covered Individuals and the Accreditation Association for Ambulatory Healthcare ("AAAHC") who (1) receive general, spinal, or other major regional anesthesia or (2) undergo surgery or other invasive procedures when receiving intravenous, intramuscular, or inhalation sedation/analgesia. Invasive procedures include, but are not limited to, percutaneous aspirations and biopsies, cardiac and vascular catheterization and endoscopies. To meet these standards:

1. A history and physical or documentation giving evidence for the procedure and the Covered Individual's readiness for the procedure must be present.
2. Informed consent must be obtained before anesthesia is administered and/or surgery performed.
3. Determinations that the Covered Individual is an appropriate candidate for planned anesthesia must be present.
4. Appropriate monitoring during administration of anesthesia with evaluation of post-op status of the Covered Individual is documented.
5. Procedure details must be written or dictated immediately after the procedure and the Covered Individual's status at its conclusion must be documented.
6. Path reports of examination of tissues removed during surgery must be a part of the medical record.
7. Relevant discharge criteria determining readiness and stability of Covered Individual for discharge must be documented.
8. Discharge instructions in follow-up care must be given in writing and reviewed with the Covered Individual or responsible adult with acknowledgment of understanding.
9. Quality and appropriateness of surgical and anesthesia services must be monitored and evaluated as part of the Quality Assurance Program (i.e., follow-up calls/contact with Covered Individuals post discharge).

Behavioral Health Documentation Guidelines

Inpatient and Outpatient

These documentation guidelines were developed by the Plan mental health specialists in conjunction with behavioral health professionals across the state, and may be used for the review of behavioral health services for applicable Health Benefit Plans. The determination of reimbursement requires adequate documentation of Covered Individual acuity and services provided. The Plan must maintain adequate and accurate clinical records.

Documentation must be legible and signed by the person providing the service. Legible documentation is required to substantiate reimbursement for services. The Plan reserves the right to retract or recover any payments made when there is absence of documentation, illegible documentation, or if documentation is insufficient to justify services billed, subject to all restrictions of applicable law.

Documentation should be complete, including positive as well as negative findings, and should be recorded in a timely manner. A progress note is generated and documented after each Covered Individual contact. The Coded Service Identifier(s) or successor codes reported on the health insurance claim form should reflect the documentation in the medical record. All medical record documentation must be maintained for five (5) years for audit purposes.

Documentation must reflect who rendered what service, why, when and to whom.

Inpatient Documentation Guidelines

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

Covered Individuals within a Facility setting must be under the medical supervision of a physician. The attending physician maintains responsibility for the total care of the Covered Individual. Although members of other disciplines write psychotherapy notes, the physician of record has the responsibility to document the Medical Necessity for the prescribed psychotherapy and the total treatment program.

Evaluations, assessments, and other services shall be made by credentialed and/or licensed professional staff according to Facility policy and professional standards.

I. ADMISSION NOTE

A. Within twenty-four (24) hours of a Covered Individual's admission, the attending physician and the nurse performing the initial assessments must personally document their findings in the medical record. Documentation must include the time the assessment was performed by the attending physician.

1. Documentation of the severity of the presenting problem must support the Medical Necessity of admission for Inpatient Services.
   a. The primary DSM-IV Axis I and Axis II diagnosis must be documented by the physician and must be consistent with the presenting problem.
2. The Covered Individual's potential for danger to self, others and/or property must be clearly documented. Documentation must indicate the following:
   a. presenting thoughts
   b. intent
   c. plan
   d. method

3. An initial diagnostic evaluation must be documented and include the following:
   a. date of exam
   b. presenting problem—supporting signs and symptoms
   c. history of present illness
   d. previous treatment and outcome
   e. medical history, (including medications & allergies)
   f. social history/family history
   g. history of alcohol and drug use
   h. mental status exam
   i. diagnosis

4. Initial treatment plan, including the goals for hospitalization, must be documented, providing the following information:
   a. an estimated Length of Stay ("LOS")
   b. initial Discharge Plan

5. Signatures and credentials are required documentation for the following:
   a. attending/attending physician
   b. all licensed staff

II. HISTORY AND PHYSICAL

Within twenty-four (24) hours of admission a History and Physical ("H&P") must be completed by a licensed physician and documented in the medical record. The H&P must evaluate the Covered Individual's physical and medical stability for treatment in an inpatient setting. An explanation of exceptions for any History and Physical component must be documented.

A. H&P documentation is to include an evaluation of the following:

1. general appearance and nutritional status
2. skin and lymph
3. head and neck
4. eyes/vision
5. ears/hearing
6. nose
7. mouth and throat
8. chest and lungs
9. breast
10. heart
11. abdomen
12. genitalia
13. rectal
14. bones, joints and muscles
15. neurological; to include the following:
    - motor
    - sensory
    - cranial nerves
    - deep tendon reflexes
    - strength
    - cerebrum

- posture, gait

16. clinical impression, to include activity level

B. Signature and credentials of the physician are required.

C. Laboratory results must be documented in a timely manner.

III. CONSULTATION SERVICES

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

B. The attending physician must order the consultation, and the provider who renders it must include a written report in the medical record.

C. All consultations must be performed by the provider billing for the service. Health Benefit Plans do not provide benefits for telephone consultations.

IV. MASTER TREATMENT PLAN

A. A master treatment plan that addresses measurable goals and objectives relating to the presenting problems and defines realistic goals for discharge must be documented in the medical record within three (3) days.

1. All therapies and disciplines involved must be addressed in the master treatment plan.
   a. The Covered Individual's strengths and weaknesses and the ability to reach realistic goals must also be documented.
   b. The treatment plan must be current and updated at least every seven (7) days.
2. Discharge planning must be documented in the treatment plan.
3. Specific follow-up plans for post discharge must be documented.

Psychological testing required for differential diagnosis and the development of a treatment plan should be ordered within three (3) days of admission and results documented in the medical record within three (3) days of completed testing.

V. PROGRESS NOTES

A. Documentation in the progress notes is required to address the Covered Individual's response to treatment.

1. After significant patient contact, all disciplines must record their assessment in the medical record. All entries must be dated, and signed by each professional, noting their credentials.
   a. Interventions, goals of the master treatment plan and coordination of services must be substantiated.
   b. An explanation of positive or negative change in the Covered Individual's condition is required.
   c. Deterioration or complication following initiation or change of medication must be documented.
   d. Ongoing documentation of the Covered Individual's mental, functional and medical stress is required.
   e. Covered Individual's response to treatment must be documented
   f. A record of the use of any physical and/or chemical restraints or seclusion must be documented.

B. The medical record must reflect daily medical and nursing documentation of the severity of illness and intensity of services rendered, and a daily progress note documented by the psychiatrist.

VI. PSYCHOTHERAPY

A. Documentation, written or dictated by the Provider, of psychotherapy sessions is required in the medical record to determine that the services were rendered and Medically Necessary.

B. The Provider must personally render all psychotherapy billed to the Health Plan. It is recognized that there are useful milieu therapy groups run by other personnel, but these milieu therapy groups are included in the Facility charge and will not be reimbursed separately by the Health Plan.

1. Patient interactions of less than 20 minutes in duration may be documented as medication evaluation, but may not be documented as psychotherapy sessions.
2. For utilization review purposes and to qualify for reimbursement, one note for each psychotherapy session is required. The psychotherapy note must indicate the following information:
   a. date of service
   b. length of session
   c. statement of therapeutic focus, including the therapist's intervention(s)
   d. periodic reference to the patient's progress
   e. individuals present at the session
   f. a separate note must be written in the Facility record for each patient in group therapy, indicating the nature of the participation at each session

Outpatient Documentation Guidelines

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

I. CLINICAL EVALUATION

A. A clinical evaluation must be documented in the medical record:
   1. The presenting problem:
      a. history of present illness
      b. evidence of personal distress
      c. impairment of functioning
   2. Medical history including medication and allergies
   3. Previous treatment and outcome
   4. Social history/family history
   5. History of alcohol and drug use
   6. Mental status exam
   7. Appropriate diagnosis
   8. Initial treatment plan with goals of treatment
      a. estimated number of treatment sessions to achieve goals
   9. Signature and credentials of Provider

II. PSYCHOTHERAPY NOTES

A. Patient interactions of less than twenty (20) minutes in duration may be documented as medication evaluation, but may not be documented as psychotherapy sessions.
B. Clinical notes must be documented in a timely manner and include:
   1. Patient's name
   2. Date of service
   3. Type and length of session
   4. Individuals present at the session
   5. Current symptoms
   6. Current level of functioning
   7. Focus of session including the therapist's intervention(s)
   8. Future directions
   9. Next scheduled appointment
   10. Summary of treatment outcome upon termination
   11. A separate note is written in the medical record for each patient in group therapy, indicating the nature of the participation at each session.
   12. Signature and credentials of Provider after each session

Credentialing

Credentialing Scope

Anthem credentials the following health care practitioners: medical doctors, doctors of osteopathic medicine, doctors of podiatry, chiropractors, and optometrists providing 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, 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 Credentials Committee ("CC").

The CC will meet at least once every forty-five (45) 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 Network 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 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 within thirty (30) calendar days of the identification of the issue. This communication will specifically notify the practitioner of his or her 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 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 Plan Programs or Networks 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 providers require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence as outlined in Anthem Credentialing Program Standards. CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process.

Initial Credentialing

Each practitioner or HDO must complete a standard application form when applying for initial participation in one or more of Anthem Plan Programs or Networks. 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") 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 providers. 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) 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 HFAP (formerly known as AOA) accredited hospital, or a Network hospital previously approved by the committee.
DEA, CDS and state controlled substance certificates The DEA/CDS must be valid in the state(s) in which practitioner will be treating Covered Individuals.
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
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 Network/Participating Provider'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 Network/Participating Provider's professional conduct and competence. This information is reviewed in order to assess whether Network/Participating Providers 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 Anthem 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 for that HDO.

Recredentialing of HDOs occur every three (3) years unless otherwise required by regulatory or accrediting bodies. Each HDO applying for continuing participation in Plan Programs or Networks must complete and submit the applicable recredentialing application, along with 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.

Site Visits

Anthem will establish specific criteria and threshold standards related to the sites where Network practitioners see Anthem Covered Individuals. These standards will address at a minimum the following: Physical accessibility for individuals with special needs, physical appearance, adequacy of examination room space, availability of appointments and adequacy of medical/treatment record keeping.

Upon receipt of a Covered Individual complaint(s) or complaints related to any of the four issues listed above, which when assessed against the criteria established exceed the threshold, Anthem will perform a site visit. The visit will be performed by an Anthem associate or agent, and will occur within sixty (60) days of receipt of the Covered Individual complaint or complaints that exceed threshold.

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) 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 Network/Participating Provider 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 Anthem Medical Director, referral to the CC, or termination. Anthem credentialing departments will report providers to the appropriate authorities as required by law.

Appeals Process

Anthem has established policies for monitoring and re-credentialing Network/Participating Providers who seek continued participation in one or more of Anthem's Plan Programs or Networks. 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 providers. Anthem also seeks to treat Network/Participating Providers and applying providers fairly, and thus provides Network/Participating Providers 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 providers 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 providers the opportunity to contest a termination of the provider's participation in one or more of Anthem's Plan Programs or Networks 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 provider's suspension or loss of licensure, criminal conviction, or Anthem's determination that the provider's continued participation poses an imminent risk of harm to Covered Individuals. A provider 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 provider's participation in one or more Plan Programs or Networks, 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.

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; and

C. Must not be currently debarred or excluded from participation in any of the following programs, Medicare, Medicaid or FEHBP.

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 Physician Specialties ("ABPS"), American Board of Podiatric Orthopedics and Primary Podiatric Medicine ("ABPOPPM") 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.

D.

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 Network AND the applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.

2. Providers 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 Healthcare Facilities Accreditation Program ("HFAP") (formerly known as AOA) accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network/Participating Provider 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) 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 provider 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. 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 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
    e.
        i. The applicant agrees that failure to provide the appropriate DEA within a ninety (90) 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) 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 of or current use of illegal drugs or history of or current alcoholism;
12. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
13. No gap in work history greater than six (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 an Anthem 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) 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/Participating Provider of similar specialty at a Network hospital 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. a NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria.
    e. nonrenewal of malpractice coverage or 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 Network/Participating Providers through ongoing sanction monitoring. Network/Participating Providers 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 Network/Participating Provider 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.

Practitioners must have a minimum of two (2) years experience post-licensure in the field in which they are applying beyond the training program or practice in a group setting where there is opportunity for oversight and consultation with a behavioral health practitioner with at least two (2) years of post licensure experience.

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").
   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 ("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.
   e. 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/Participating Provider as applicable by the state licensing board. For those who possess a DEA Certificate, the appropriate CDS Certificate if required. The DEA/CDS must be valid in the state(s) in which the provider 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 provider'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. 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. Liability insurance acceptable to Anthem.
   4. Cooperate in Anthem's UM and quality improvement programs.

B. Additional Participation Criteria for HDO by Provider Type:

   1. Hospital: Must be accredited by TJC, NIAHO or HFAP (formerly referred to as AOA Hospital Accreditation Program)

   2. Ambulatory Surgery Center: Must be accredited by TJC, HFAP, Accreditation Association for Podiatric Surgical ("AAPSF"), Accreditation Association for Ambulatory Health Care ("AAAHC"), American Accreditation of Ambulatory Surgery Facilities ("AAAASF"), or Institute for Medical Quality ("IMQ").

   3. Home Health Care Agency: Must be accredited by TJC, HFAP, Community Health Accreditation Program ("CHAP") or Accreditation Commission for Health Care ("ACHC").

   4. Skilled Nursing Facility: Must be accredited by TJC, HFAP or CARF.

5. Nursing Home: Must be accredited by TJC.

6. Free Standing Cardiac Catheterization Facilities: Must be accredited by the TJC or HFAP (may be covered under parent institution).

7. Lithotripsy Centers: Must be accredited by TJC.

8. Behavioral Health Facility:
   a. The following behavioral health facilities must be accredited by the TJC or CARF as indicated.
      i Acute Care Hospital – Psychiatric Disorders (TJC, HFAP or NIAHO)
      ii Residential Care – Psychiatric Disorders (TJC, HFAP, NIAHO or CARF)
      iii Partial Hospitalization/Day Treatment – Psychiatric Disorders (TJC, HFAP, NIAHO or CARF for programs associated with an acute care facility or residential treatment facilities.)
      iv Intensive Structure Outpatient Program – Psychiatric Disorders (TJC, HFAP or NIAHO for programs affiliated with an acute care hospital or health care organization that provides psychiatric services to adults or adolescents or CARF if program is a residential treatment center providing psychiatric services)
      v Acute Inpatient Hospital – Chemical Dependency/Detoxification and Rehabilitation (TJC, HFAP or NIAHO)
      vi Acute Inpatient Hospital – Detoxification Only Facilities (TJC, HFAP, NIAHO)
      vii Residential Care – Chemical Dependency (TJC, HFAP, NIAHO or CARF)
      viii Partial Hospitalization/Day Treatment – Chemical Dependency (TJC or NIAHO for programs affiliated with a hospital or health care organization that provides drug abuse and/or alcoholism treatment services to adults or adolescents; Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS") or CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents)
      ix Intensive Structure Outpatient Program – Chemical Dependency (TJC or NIAHO 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)

Quality Management Programs

Quality Improvement Programs

"Quality Improvement Program" means activities which may include, without limitation, evaluation of and efforts to improve the quality and efficiency of the use of Health Services, procedures and facilities on a prospective, concurrent or retrospective basis.

Anthem conducts an ongoing review of qualifications to determine Hospital participation in its Networks. Hospitals participating in Anthem Networks are expected to implement and maintain Quality Programs in accordance with Anthem's requirements and performance targets, including, but not limited to:

1. Governing Body or Advisory Board – Facility shall have a board of directors or trustees or other governing entity appropriate to the type of Hospital seeking participation status.

2. Upon request, Facility shall also provide Anthem or its designees with reasonable data that is commonly accepted to be an indicator of Facility's quality of care.

Accreditation or Certification

Facility shall be accredited by The Joint Commission ("TJC") or the Health Care Facilities Accreditation Program ("HFAP") and/or be certified as a provider of care pursuant to Title XVIII of the Medicare Program. Additionally,

Facility shall hold a current unlimited non-probationary license as an acute care facility in all jurisdictions requiring licensure of acute care facilities.

Additionally, upon request, the following applicable information shall be required:

a) A copy of TJC or HFAP accreditation letter must be submitted for review by Anthem, along with any explanation of adverse conditional, probationary, or non-accreditation status in the last seven (7) years, if accredited. If not accredited by TJC or HFAP Anthem has the right to request further documentation and the option to conduct an onsite quality assessment of the Facility.

b) Any recommendations for improvement from TJC, HFAP, CMS or state licensing agency must also be submitted to Anthem upon request.

Compliance Documentation

The following information shall be provided to Anthem by Facility upon initial execution of the Agreement and also upon written request by Anthem, not more than once annually.

1. A copy of Facility's current unlimited non-probationary license as a general acute care facility, along with any explanations of disciplinary action in the last seven (7) years.
2. A copy of Facility's current unrestricted Federal Drug Enforcement Agency Registration Certificate along with any explanations of disciplinary action in the last seven (7) years.
3. A copy of Facility's current Medicare and Medicaid Certification along with any explanation of disciplinary actions or financial penalties in the last seven (7) years.
4. A copy of the most recent audited Facility financial statements for the past two (2) years.
5. A copy of Facility's current medical malpractice insurance face sheet. If Facility is located in Indiana, Facility shall provide documentation that Facility is a qualified healthcare provider under the Indiana Malpractice Act and documentation of Facility's participation in the Indiana Patient Compensation Fund.

Facility Audit

Enterprise Audit Policy

This Enterprise Audit Policy applies to Network/Participating Providers. If there is conflict between this Policy and the terms of the applicable Facility 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 Network/Participating Provider.

Coverage is subject to the terms, conditions, and limitations of an individual 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 Network/Participating Provider that describes the duties and obligations of Anthem and the Network/Participating Provider, and which contains the terms and conditions upon which Anthem will reimburse Network/Participating Provider for health care services rendered by Network/Participating Provider to Anthem Covered Individual(s).

- Appeal means Anthem's review, conducted at the written request of a Network/Participating Provider and pursuant to this Policy, of the disputed portions of the Audit Report.

- Appeal Response means Anthem's written response to the Appeal after reviewing all Supporting Documentation provided by Network/Participating Provider.

- Audit means a qualitative or quantitative review of services or documents relating to such services rendered to be rendered, by Network/Participating Provider, and conducted for the purpose of determining whether such 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 Network/Participating Provider that Anthem 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 belief that the overpayment exists. Unless otherwise stated in the Agreement between the Network/Participating Provider and Anthem, Audit Reports shall be sent to Network/Participating Provider 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.

- Network/Participating Provider means an entity with which Anthem has a written Agreement.

- Provider Manual means the proprietary Anthem document available to Network/Participating Provider, which outlines certain Anthem Policies.

- Recoupment means the recovery of an amount paid to Network/Participating Provider which Anthem has determined constitutes an overpayment not supported by an Agreement between the Network/Participating Provider and Anthem. A Recoupment is generally performed against a separate payment Anthem makes to the Network/Participating Provider which payment 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 Network/Participating Provider documentation that supports the Network/Participating Provider's claim or position that no overpayment has been made by Anthem.

Procedure:

1. Review of Documents. Plan or its designee will request in writing or verbally, final and complete itemized bills for all Claims under review. The Network/Participating Provider will supply the requested documentation in the format requested by Plan within thirty (30) calendar days of Plan's request.

2. Scheduling of Audit. After review of the documents submitted, if Plan determines an Audit is required, Plan will call the Network/Participating Provider to request a mutually satisfactory time for Plan to conduct an Audit; however, the Audit must occur within forty- five (45) calendar days of the request.

3. Rescheduling of Audit. Should Network/Participating Provider desire to reschedule an Audit, Network/Participating Provider must submit its request with a suggested new date, to the Plan in writing at least seven (7) calendar days in advance of the day of the Audit. Network/Participating Provider's new date for the Audit must occur within thirty (30) calendar days of the date of the original Audit. Network/Participating Provider may be responsible for cancellation fees incurred by Plan due to Network/Participating Provider's rescheduling.

4. Under-billed and Late-billed Claims. During the scheduling of the Audit, Network/Participating Provider may identify Claims for which Network/Participating Provider under-billed or failed to bill for review by Plan during the Audit. Under-billed or late-billed claims not identified by Network/Participating Provider before the Audit commences will not be evaluated in Audit. These Claims may, however, be submitted (or resubmitted for under-billed claims) to Plan for adjudication.

5. Scheduling Conflicts. Should the Network/Participating Provider fail to work with Plan in scheduling or rescheduling the Audit, Plan retains the right to conduct the Audit with a seventy-two (72) hour advance written notice, which Plan may invoke at any time. While Plan prefers to work with the Network/Participating Provider in finding a mutually convenient time, there may be instances when Plan must respond quickly to requests by

regulators or its clients. In those circumstances, Plan will send a notice to the Network/Participating Provider to schedule an Audit within the seventy-two (72) hour timeframe.

6. On-Site and Desk Audits. Plan may conduct Audits from its offices or on-site at the Network/Participating Provider's location. If Plan conducts an Audit at a Network/Participating Provider's location, Network/Participating Provider will make available suitable work space for Plan's on-site Audit activities. During the Audit, Plan will have complete access to the applicable health records including ancillary department records and/or invoice detail without producing a signed member authorization. When conducting credit balance Audits, Network/Participating Provider will give Plan or its designee a complete list of credit balances for primary, secondary and tertiary coverage, when applicable. In addition, Plan will have complete access to Network/Participating Provider's patient accounting system to review payment history, notes and insurance information to determine validity of credit balances. If the Network/Participating Provider refuses to allow Plan access to the items requested to complete the Audit, Plan may opt to complete the Audit based on the information available. All Audits shall be conducted free of charge despite any Network/Participating Provider policy to the contrary.

7. Completion of Audit. Upon completion of the Audit, Plan will generate and give to Network/Participating Provider 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, Plan will discuss with Network/Participating Provider, 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 Network/Participating Provider agrees with the Audit findings, and has no further information to provide to Plan, then Network/Participating Provider may sign the final Audit Report acknowledging agreement with the findings. At that point, Network/Participating Provider has thirty (30) calendar days to reimburse Plan the amount indicated in the final Audit Report. Should the Network/Participating Provider disagree with the final Audit Report generated during the exit interview, then Network/Participating Provider may either supply the requested documentation, or Appeal the Audit findings.

8. Network/Participating Provider Appeal's. See Audit Appeal Policy.

9. No Appeal. If the Network/Participating Provider 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 Plan 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 Plan along with a short explanation of the importance of each of the documents in the Audit process. It is important to note that Network/Participating Providers must comply with applicable state and federal record keeping requirements.

A. Confirm that services were delivered by the Network/Participating Provider in compliance with the physician's plan of treatment.

Auditors will verify that Network/Participating Provider's plan of treatment reflected the services delivered by the Network/Participating Provider. 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 Network/Participating Provider may present other documents substantiating the treatment or service, such as established institutional policies, professional licensure standards that reference standards of care, or business practices justifying the service or supply. The Network/Participating Provider 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 Plan'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 services provided to the Covered Individual may exist within the Network/Participating Provider's ancillary departments in the form of department treatment logs, daily charge records, individual service/order tickets, and other documents. Plan 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 Network/Participating Provider 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 Network/Participating Provider Appeals of such Audits.

Exceptions: This Audit Appeal Policy does not apply to Medicare Advantage, Medicare Private Fee for Service or New York physician Claims.

Procedure:

1. Unless otherwise expressly set forth in an Agreement, Network/Participating Provider shall have the right to Appeal the Audit Report. An Appeal of the Audit Report must be in writing and received by Anthem within thirty (30) calendar days of the date of the Audit Report. The request for Appeal must specifically detail the findings from the Audit Report that Network/Participating Provider disputes, as well as the basis for the Network/Participating Provider's belief that such finding(s) are not accurate. All findings disputed by the Network/Participating Provider in the Appeal must be accompanied by relevant Supporting Documentation. If no Supporting Documentation is submitted to substantiate the basis for the Network/Participating Provider's belief that a particular finding is not accurate the Network/Participating Provider will be notified of the denial and have thirty (30) calendar days to send a remittance check to Anthem, if applicable in the state. If no remittance check is received within the thirty (30) day timeframe or if Network/Participating Provider does not respond to an Audit Report within thirty (30) calendar days of the date of such Report, Anthem will begin Recoupment proceedings within ten (10) days, unless expressly prohibited by an Agreement.

2. A Network/Participating Provider's written request for an extension to submit an Appeal complete with Supporting Documentation or payment will be reviewed by Anthem on a case-by-case basis. If the Network/Participating Provider chooses to request an Appeal extension, the request should be submitted in writing within thirty (30) calendar days of receipt of the Audit Report or within thirty (30) calendar days of the receipt of Anthem's appeal response and submitted to the Appeals coordinator identified within the Audit Report. One Appeal extension may be granted during the Appeal process at Anthem's sole discretion, for up to thirty (30) calendar days from the date the Appeal would otherwise have been due. A written notification of approval or denial of an Appeal extension will be mailed to the Network/Participating Provider within seven (7) calendar days. Any extension of the Appeal timeframes contained in this Policy shall be expressly conditioned upon the Network/Participating Provider'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 shall issue an Appeal Response to the Network/Participating Provider. Anthem's response shall address each matter contained in the Network/Participating Provider's Appeal. If appropriate, Anthem's Appeal Response will indicate what adjustments, if any, shall be made to the overpayment amounts outlined in the Audit Report. Anthem's response shall be sent via certified mail to the Network/Participating Provider within sixty (60) calendar days of the date Anthem received the Network/Participating Provider's Appeal and Supporting Documentation. Revisions to the Audit data will be included in this mailing if applicable.

4. The Network/Participating Provider shall have thirty (30) calendar days from the date of Anthem's response to send a response or, if appropriate in the state, a remittance check to Anthem. If no Network/Participating Provider response or remittance check (if applicable) is received within the thirty (30) day timeframe, Anthem shall recoup the amount contained in Anthem's response, and a confirming Recoupment notification will be sent to the Network/Participating Provider.

5. Upon receipt of a timely Network/Participating Provider response, complete with Supporting Documentation as required under this Policy, Anthem shall formulate a final Appeal Response. Anthem's final Appeal Response shall address each matter contained in the Network/Participating Provider's response. If appropriate, Anthem'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 final Appeal Response shall be sent via certified mail to the Network/Participating Provider within thirty (30) calendar days of the date Anthem received the Network/Participating Provider response and Supporting Documentation. Revisions to the Audit Report will be included in this mailing if applicable.

6. If applicable in the state, the Network/Participating Provider shall have thirty (30) calendar days from the date of Anthem's final Appeal Response to send a remittance check to Anthem. If no remittance check is received within the thirty (30) day timeframe, Anthem shall recoup the amount contained in Anthem's final Appeal Response, and a confirming Recoupment notification will be sent to the Network/Participating Provider.

360° HEALTH®

360° Health®
A Revolution in Care.

What is 360° Health®?

It's one of the industry's most comprehensive health services programs. In fact, this brand new integrated group of health services is designed to help Anthem Covered Individuals:

- Manage and maintain their health
- Make more informed health care decisions
- Maximize the value of their health care benefits

We developed 360° Health® because we want our Covered Individuals to be completely surrounded with the information they need to manage their health. This new program offers Covered Individuals access to services ranging from preventive care, case management and care coordination, such as:

- Online health and wellness resources
- Discounts on health-related products and alternative medicine therapists
- Twenty-four/seven (24/7) professional guidance and support
- Condition management to help those with serious health issues

In a nutshell, 360° Health includes tools that our Covered Individuals and their families can use to manage their health care needs. Please see the information listed below for details about this revolutionary program!

How Health Needs are Being Met with 360° Health

Health Resources

If having access to a wealth of health and wellness information is what our Covered Individuals crave, then they can tap into:

Healthy Living, powered by WebMD® - a resource of information for Covered Individuals; including health assessments, links to articles, alerts and recalls, tools and calculators.

Covered Individual Newsletters – a newsletter for Covered Individuals that includes detailed information about various health topics.

Women's Health E-Newsletter – a free monthly newsletter created for women of all ages.

Preventive Care Guidelines – review guidelines on health issues for women, men, children and youth.

On-Call's® Audio Health Library – listen to recorded messages addressing hundreds of general health topics in English and Spanish by calling (866) 277-2367.

Health Extras

Our interactive tools and health discounts will help Covered Individuals save money and learn more about keeping themselves healthy with resources like:

Healthy Extensions Discounts – discounts are available for alternative therapies, vision and dental services, hearing aids, fitness club Covered Individuals and weight management programs.

Interactive online programs offered by WebMD® – access items such as tracking tools for diet, fitness and medication needs.

The Last Cigarette ("TLC") – a smoking cessation program that helps Covered Individuals and their families live smoke free.

Walking Works – a program that helps Covered Individuals walk their way to better health.

Health Guidance

There's nothing like being able to receive helpful information twenty-four/seven24/7 on different events (such as before, during or after a facility stay). And, with 360° Health, Covered Individuals can use the tools that are right for them:

Access an online database for Facility quality – Covered Individuals preparing for a Facility stay will probably have questions about the Facility that will be providing their care. That is why we provide an online tool to help Covered Individuals educate themselves about the Facilities available to them. To learn more, registered Covered Individuals can log on to Healthcare Advisor by Subimo® by visiting the Covered Individual Access section of the Anthem Web Site (www.anthem.com).

BlueChoice On-Call® – Health issues don't follow a nine to five (9 to 5) schedule. That is why Covered Individuals can speak with a registered nurse twenty-four/seven 24/7 by calling (866) 277-2367.

Baby Connection [sm] – Studies have indicated that many preterm births can be avoided with the right prenatal care. Covered Individuals may activate their Covered Individual in our maternity management program, as well as find answers and support by calling (866) 664-5404.

Centers of Medical Excellence ("CME")

Anthem Centers of Medical Excellence ("CME") Transplant Network

The CME designation is awarded by Wellpoint to those programs meeting the participation requirements for WellPoint's transplant Network and all other future specialty Networks developed by WellPoint. Each center 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.

Blue Distinction® Centers of Excellence Programs

Blue Distinction® is a designation *awarded by the Blue Cross and Blue Shield* companies to medical Facilities that have demonstrated expertise in delivering quality healthcare. The designation is based on rigorous, evidence-based, objective selection criteria established in collaboration with expert physicians' and medical organizations' recommendations. Its goal is to help consumers find quality specialty care on a consistent basis, while enabling and encouraging healthcare professionals to improve the overall quality and delivery of care nationwide.

At the core of the Blue Distinction program are the Blue Distinction Centers for Specialty Care®, Facilities that we recognize for their distinguished clinical care and processes in the areas of:

- Bariatric Surgery
- Cardiac Care
- Complex and Rare Cancers
- Knee and Hip Replacement
- Spine Surgery

Blue Distinction® Centers for Transplants

The Blue Distinction® Centers for Transplants program is a program designated by the Blue Cross Blue Shield Association to facilities that meet objective, evidence-based thresholds for clinical quality, developed in conjunction with expert physicians and medical organizations.

Blue Distinction® Centers for Transplants have demonstrated their commitment to quality care, resulting in better overall outcomes for transplant patients. They offer comprehensive transplant services through a coordinated, streamlined transplant management program. To date, they have designated more than 80 facilities nationwide – representing more than 330 transplant programs that meet evidence-based selection criteria.

Additional value-added services provided within this transplant network include global pricing, financial savings analysis and global claims administration support, as well as support services such as referral management, patient satisfaction survey reports and transplant-related continuing education programs for Blue companies.

The Blue Distinction® Centers for Transplants program examines the following transplant types:

- heart
- lung (deceased and living donor)
- combination heart/lung
- liver (deceased and living donor)
- simultaneous pancreas kidney (SPK)
- pancreas (PAK/PTA)
- bone marrow/stem cell (autologous & allogeneic)

Product Summary

BlueCard Website

Please refer to the Communications section on www.anthem.com or its successor for additional information.

Federal Employee Program (FEP) Website

Please refer to the Federal Employee Program (FEP) Website at www.fepblue.org for additional information.

Other Products

Please refer to the Plans & Benefits section on www.anthem.com or its successor for additional information.

Medicare Advantage

Medicare Advantage Provider Website

Please refer to the Medicare Advantage section on www.anthem.com or its successor for additional information.

Appendices

Affiliates List

The following list can also be found on www.anthem.com:

Anthem Health Plans of Virginia, Inc. DBA Anthem Blue Cross and Blue Shield
HealthKeepers, Inc.

Links

Contact Us

http://www.anthem.com/wps/portal/ahpprovider?content_path=provider/va/f5/s5/t0/pw_ad076697.htm&rootLevel=4&state=va&label=Contact%20Us

Electronic data interchange (EDI)

www.anthem.com/edi

Medical Policy and Clinical UM Guidelines Link

http://www.anthem.com/wps/portal/ahpprovider?content_path=provider/va/f4/s3/t0/pw_m008656.htm&state=va&rootLevel=0&label=Medical%20Coverage%20Guidelines%20&%20Clinical%20UM%20Guidelines

Point of Care Portal

https://poc.anthem.com/POC/Login/POC_Login.jsp

Centers of Medical Excellence

http://www.bcbs.com/innovations/bluedistinction

BlueCard Website

http://www.bcbs.com/coverage/bluecard/

Federal Employee Program (FEP) Website

http://www.fepblue.org/

Medicare Advantage

http://www.anthem.com/medicare/